

1-0902-13135-2

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE BOARD OF DENTISTRY

In the Matter of the Dental License of  
William P. Rolfe, D.D.S.  
License No: D8343

**FINDINGS OF FACT,  
CONCLUSIONS OF LAW AND  
RECOMMENDATION**

The above-entitled matter came on for hearing before Administrative Law Judge George A. Beck on November 13, 2000, at the Office of Administrative Hearings in the City of Minneapolis, Minnesota. The hearing continued on ten subsequent days and concluded on November 30, 2000. The hearing record closed on March 19, 2001, upon receipt of the final written memorandum.

Paul R. Kempainen, Assistant Attorney General, 1400 NCL Tower, 445 Minnesota Street, St. Paul, Minnesota 55101-2131 appeared on behalf of the Complaint Committee ("Committee") of the Minnesota Board of Dentistry ("Board"). Ronald I. Meshbesh, Esq. and Konstandinos Nicklow, Esq. of the firm of Meshbesh & Spence, 1616 Park Avenue, Minneapolis, Minnesota 55404, appeared on behalf of the Respondent, William P. Rolfe, D.D.S.

**NOTICE**

This Report is a recommendation, **not** a final decision. The Board of Dentistry will make the final decision after a review of the record. The Board may adopt, reject or modify the Findings of Fact, Conclusions and Recommendations. Under Minn. Stat. § 14.61, the final decision of the Board shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Board. Parties should contact Marshal Shragg, Executive Director, Minnesota Board of Dentistry, 2829 University Avenue SE, Suite 450, Minneapolis, MN 55414 to ascertain the procedure for filing exceptions or presenting argument.

**STATEMENT OF ISSUES**

Did the Respondent:

- a. engage in conduct unbecoming a dentist?
- b. habitually overindulge in the use of intoxicating liquors?

- c. improperly administer nitrous oxide to himself or others for nondental purposes?
- d. improperly prescribe and/or use a controlled substance?
- e. have a disability adversely affecting his ability to perform as a licensed dentist?
- f. fail to maintain adequate dental records? or
- g. fail to provide appropriate periodontal diagnosis or treatment?

Based upon all of the proceedings herein, the Administrative Law Judge makes the following:

### **FINDINGS OF FACT**

#### The Respondent

1. The Respondent, William P. Rolfe, D.D.S. is 50 years old.<sup>[1]</sup> He was first licensed to practice dentistry in Minnesota in 1976, and is currently subject to the jurisdiction of the Minnesota Board of Dentistry.<sup>[2]</sup> His license was suspended by the Board on August 16, 2000.

2. Respondent received a B.S. degree from the University of Minnesota in 1974 and received his dental degree from the University of Minnesota in June, 1976.<sup>[3]</sup> Thereafter, he served a one-year residency at Hennepin County Medical Center, worked one year as an associate dentist in a private general practice in Excelsior, Minnesota, and spent one-and-a-half years as a resident at the Royal Dental Hospital in London, England.<sup>[4]</sup> Upon returning to Minnesota he first worked as a full-time clinical instructor at the University of Minnesota Dental School for about one year.<sup>[5]</sup> Starting in 1981, he continued as a part-time instructor at the University of Minnesota for about three years.

3. Respondent opened his private practice in Hopkins, Minnesota in 1981 where he has worked continuously for the last 20 years.<sup>[6]</sup> At the time of his suspension by the Board, he maintained three Twin Cities offices – Hopkins, Eagan and Blaine – the latter two he opened in 1986 and 1991, respectively.<sup>[7]</sup>

4. Respondent had approximately 6,000 active patients when he was suspended and has treated upwards of 20,000 patients since he opened his practice.<sup>[8]</sup> He has a busy practice and a large number of loyal patients, many of whom have been his patients for a long time.<sup>[9]</sup> Respondent has only missed one day of work in the last 20 years.<sup>[10]</sup> He works 8-10 hour days and used to work 6-7 days a week, until recently.<sup>[11]</sup>

5. In addition to his practice, Respondent has volunteered his services at the Union Gospel Mission since finishing Dental School.<sup>[12]</sup> He works *pro bono* at the Mission about six times per year, in addition to doing other *pro bono* work at his office.<sup>[13]</sup>

6. The Respondent was a high school hockey player,<sup>[14]</sup> and continued playing hockey during his residency at Hennepin County Medical Center, where the doctors and staff formed a team.<sup>[15]</sup> He has played hockey with the doctors and staff personnel once a week for the last 20-25 years.<sup>[16]</sup> In addition to hockey, Respondent has played volleyball approximately once a week for the last four years, exercises regularly, water skis, snow skis and plays golf.<sup>[17]</sup>

7. Steven Saliterman, M.D. ("Dr. Saliterman") has known Respondent as a social friend and has been his regular physician since the early 1980s.<sup>[18]</sup> He graduated from the Mayo Medical School in 1980<sup>[19]</sup> and has been in practice for 20 years.<sup>[20]</sup> Dr. Saliterman has also been a senior aviation medical examiner for 20 years and evaluates several hundred pilots a year for issues including, but not limited to, chemical dependency.<sup>[21]</sup> Respondent is Dr. Saliterman's dentist.<sup>[22]</sup>

8. Although Respondent is active athletically, he has an arthritic hip condition.<sup>[23]</sup> According to Dr. Saliterman, he has degenerative joint disease of the hips, a debilitating condition that is painful, that can be immobilizing, that continues to advance, and for which there is no cure.<sup>[24]</sup> The only prescriptions Respondent uses are over-the-counter analgesics and non-steroidal anti-inflammatory drugs.<sup>[25]</sup> He will probably need hip replacements in the near future.<sup>[26]</sup> Dr. Saliterman has never seen evidence that the Respondent was chemically dependent on drugs, alcohol or any other addictive substance, and has never seen indications of alcohol abuse by the Respondent.<sup>[27]</sup>

#### Physical Contact with Patients

9. While performing dental procedures, Respondent usually sits at an 8 o'clock position (with 12:00 representing the patient's head and 6:00 the feet). As a result of this position, and the height of his chair, there is occasional contact between Respondent's forearm, between his elbow and wrist, and a patient's upper chest or breastbone area. He does not put his forearm on a patient's chest and leave it there for long periods of time.<sup>[28]</sup> Respondent has never had a patient complain to him personally about the contact between his forearm and a patient's chest area.<sup>[29]</sup> He believes this position minimizes his hip pain.<sup>[30]</sup> Respondent admits that when resting his forearm on a female patient's chest it is possible to come in contact with that female's breasts.<sup>[31]</sup>

10. Respondent believes that this was a practice he learned in dental school during the mid-1970's.<sup>[32]</sup> At the hearing, Respondent demonstrated that when his operatory chair was low, Respondent's forearm would be in the middle of a patient's chest.<sup>[33]</sup> The higher the dentist's chair, the less likelihood there would be of contact with the patient's chest.<sup>[34]</sup> If Respondent used the recognized 11 or 12 o'clock positions there would be no need of forearm contact with a patient's chest.<sup>[35]</sup>

11. A textbook offered into evidence, entitled “Four-handed Dentistry”,<sup>[36]</sup> does not specifically state that it is either proper or improper to rest the forearm on a patient’s chest.<sup>[37]</sup> However, it does not picture a dentist in that position. The textbook does recommend against an 8 o’clock position since it leads to poor posture on the part of the dentist and requires extension of the dentist’s arm that is not desirable.<sup>[38]</sup> The illustrations show the dentist in a seated position at a level higher than the patient.<sup>[39]</sup>

12. The practice of resting a forearm on a patient’s chest caused concern for two of Respondent’s employees, dental hygienist M.E.H. and registered dental assistant, P.B. They were especially uncomfortable about his resting his arm on female patients.<sup>[40]</sup> Patients complained to dental hygienist M.E.H. about this contact occurring.<sup>[41]</sup> Sometime in 1998, M.E.H. had an after-work-hours meeting with Respondent in the Hopkins office to express her concern about this practice, at which time Respondent’s father came in and overheard the conversation.<sup>[42]</sup> Respondent told her that he learned this position in dental school and would continue with the practice.<sup>[43]</sup> M.E.H. told him that if he just raised the level of his dentist chair there would be no need to touch a patient’s chest.<sup>[44]</sup>

13. Jeffrey Erickson, D.D.S., is a dental school contemporary and acquaintance of Respondent.<sup>[45]</sup> He is a 49-year-old dentist who grew up in the Twin Cities area.<sup>[46]</sup> He graduated from the University of Minnesota Dental School in 1976, and from the University of Minnesota Dental School graduate program in endodontics in 1978.<sup>[47]</sup> Dr. Erickson set up his own dental clinic in 1978.<sup>[48]</sup> In his opinion it is appropriate to occasionally come into contact with patients’ chests, female or male.<sup>[49]</sup> Dr. Erickson believes it is nearly impossible for a dentist to “do the job” without occasionally having an arm or hand come in contact with a patient’s chest – male and female.<sup>[50]</sup> In his opinion, some procedures require torque and there may be a need for a dentist’s arm to come in contact with the patient’s chest in order to get the job done.<sup>[51]</sup> Dr. Erickson states that contact will also occur between a dentist’s arm and patient’s chest in simply giving an injection when the patient is a barrel chested man or a large chested woman.<sup>[52]</sup> He believes this falls within proper boundaries between male dentists and female patients<sup>[53]</sup>

14. Thomas D. Larson, D.D.S., M.S.D., is Associate Dean of Academic Affairs at the University of Minnesota (“U of M”) School of Dentistry. He graduated from the University of Minnesota in 1970 and has taught there continuously since 1973, while at the same time practicing general dentistry part-time.<sup>[54]</sup> Dr. Larson is of the opinion that resting forearms on patients’ chests was never taught as an accepted position at the U of M Dental School, either in the mid-1970’s or any time since.<sup>[55]</sup> To the contrary, dental students were specifically warned that for female patients in particular, appropriate physical contact would only be from the clavicle up.<sup>[56]</sup> Dental students were also taught that resting the forearm on a patient’s chest would be ergonomically incorrect because of the need to keep the wrist straight and not bent.<sup>[57]</sup>

15. James Q. Swift, D.D.S., is a full-time professor at the U of M School of Dentistry.<sup>[58]</sup> Before starting at the U of M in 1989, Dr. Swift served four years as an instructor at the University of Oklahoma Dental School.<sup>[59]</sup> His specialty is oral and

maxillofacial surgery.<sup>[60]</sup> Dr. Swift also served a one-year residency in general practice dentistry and has, over his career in dental education, engaged in frequent interaction with general dentistry faculty and students.<sup>[61]</sup> He is not currently in general practice. Among other subjects, Dr. Swift teaches courses related to professional ethics and conduct, as well as the proper use and administration of nitrous oxide.<sup>[62]</sup>

16. In Dr. Swift's opinion it is improper, under the standards in Minnesota, for a dentist to rest or touch a forearm on the chests of either female or male patients.<sup>[63]</sup> An additional consideration for female patients is that any contact by the dentist in and around the breasts would definitely be inappropriate.<sup>[64]</sup> Such contact is unnecessary to render dental treatment because the dentist's body can be positioned and access to the oral cavity can be made without touching the patient's chest, particularly if the dentist's chair is elevated above the level of the patient, as it should be.<sup>[65]</sup> Normally a dentist's chair is above the level of the patient so that the forearm is at a right angle to the upper arm.<sup>[66]</sup> In Dr. Swift's opinion proper professional boundaries between a dentist and patient requires that care be rendered without inappropriate contact to any part of the patient's body other than in and around the oral cavity.<sup>[67]</sup>

17. Respondent also sometimes placed dental instruments on the napkin covering the chests of both female and male patients near the collarbone.<sup>[68]</sup> When doing this to female patients, Respondent's hands could come into close proximity to their breasts.<sup>[69]</sup> Respondent would, sometimes, do this even when a dental assistant was present to take the instruments directly from him, and when a dental tray was close by on which to place the instruments.<sup>[70]</sup>

18. Respondent does not place dental instruments on patients' chests regularly, however, and, when it does happen, it is only for a brief period of time.<sup>[71]</sup> The record does not reflect any patient or co-employee complaint or concern regarding Respondent's placing of dental tools on patient's chests.<sup>[72]</sup> Both Respondent and Dr. Erickson stated that this was a practice they learned in dental school.<sup>[73]</sup> However, in dental school there was seldom a dental assistant available to take instruments from students.<sup>[74]</sup>

19. In the mid-1970's a shortage of dental assistants at the dental school meant that four-handed dentistry could not be practiced and, consequently, on occasion, students would have to place an instrument on the patient's chest from the clavicle area up.<sup>[75]</sup> However, dental students were warned specifically that for female patients they had to be very careful to avoid inappropriate touching of the chest.<sup>[76]</sup> There was also a danger in placing instruments on the chest because if the patient moved, the instruments might fall off.<sup>[77]</sup> So while it had to be done in the dental school at the time, it was not encouraged.<sup>[78]</sup> Students were taught that it was better to place instruments on the flat surface of the dental tray.<sup>[79]</sup>

20. In Dr. Larson's opinion the standard of practice when a dental assistant is present, and four-handed dentistry can be used, is to not place anything on a patient's chest, except in the instance of a time sensitive procedure, such as taking an impression.<sup>[80]</sup> Dr. Larson gave specific examples of when it is appropriate to lay a

dental tool on a patient's chest and testified that he would expect that dental tools are placed on a patient's chest in dental offices on a daily basis.<sup>[81]</sup> Dr. Larson further testified there are occasions when a dental assistant is not available, and that even he is more likely to place dental tools on a patient's chest under such circumstances.<sup>[82]</sup>

21. Dr. Swift's opinion is that any practice of regularly placing instruments on patients' chests is below the standard of care for dentists in Minnesota.<sup>[83]</sup> He believes this is because of the danger involved in placing sharp instruments on patients, the potential lack of sterility in doing so, the lack of a stable flat surface creating a danger of instruments falling off, and the violation of the patient's personal space that does not need to occur.<sup>[84]</sup> With female patients in particular there would be an unnecessary risk of inappropriate contact with the breasts.<sup>[85]</sup>

22. Dr. Erickson's opinion is that it is not below the standard of care to rest a dental tool or instrument on the napkin on a patient's chest.<sup>[86]</sup> Although he doesn't routinely do it, he will on occasion lay dental instruments on the napkin on a patient's chest.<sup>[87]</sup> Furthermore, in terms of sterilization, Dr. Erickson believes that there is no difference between the bib on a patient's chest and the paper covering on an instrument tray.<sup>[88]</sup> Dr. Erickson believes it is "common practice" in the dental profession to occasionally lay an instrument on a patient's chest, both in the Twin Cities and in the State of Minnesota.<sup>[89]</sup>

23. Respondent does not always have an assistant in the operatory when he is working on female patients,<sup>[90]</sup> even when he has dental assistants available. However, he has a dental assistant present most of the time.<sup>[91]</sup>

24. In Dr. Swift's opinion the standard of care in Minnesota is that a dentist and a patient of the opposite sex are never left alone by themselves in the operatory.<sup>[92]</sup> He believes there should always be someone else working with the dentist, particularly if the patient is under nitrous oxide sedation.<sup>[93]</sup> Dr. Larson believes that a dental assistant should usually be present, but not at all times.<sup>[94]</sup>

25. Respondent sometimes made comments to young female patients in the dental office about their appearance.<sup>[95]</sup> He talked about patient M.S.'s clothing and during one of her appointments in 1991 Respondent remarked to her "I'm surprised you didn't dress up for me," which made her feel uncomfortable.<sup>[96]</sup> Respondent would sometimes spend extra time with younger female patients.<sup>[97]</sup> On one occasion Respondent came into Dr. John Dunn's operatory while Dunn was working on a young, attractive female who was a friend of Dr. Dunn's mother.<sup>[98]</sup> Respondent then said to Dr. Dunn, while looking at the patient: "Are all your patients models?"<sup>[99]</sup> This embarrassed the young woman, who became flushed.<sup>[100]</sup> In Dr. Dunn's opinion it was an inappropriate comment by Respondent.<sup>[101]</sup> Respondent once handed out invitations to young female patients for a singles event he had helped to plan.<sup>[102]</sup>

Patient M.S.

26. In January 1991, a young 21-year-old woman named M.S. began seeing Respondent as her dentist.<sup>[103]</sup> Respondent scheduled M.S. for a number of appointments throughout 1991. At each appointment he administered nitrous oxide to her at her request.<sup>[104]</sup> Most of the time at these appointments only Respondent and M.S. would be in the operatory however, the dental assistant sometimes did a drying procedure.<sup>[105]</sup> Respondent would often lay instruments on M.S.'s bib, and rest his arm on her chest while he was working.<sup>[106]</sup>

27. M.S.'s final appointment with Respondent was on January 18, 1992, when she had an appointment late in the afternoon.<sup>[107]</sup> Although an assistant was in the office, only Respondent and M.S. were in the operatory at times.<sup>[108]</sup> The assistant was present to dry the filling.<sup>[109]</sup> Respondent administered nitrous oxide to M.S.<sup>[110]</sup> This made her feel sleepy and she went in and out of sleep. She woke up periodically.<sup>[111]</sup> When she was awake M.S. felt Respondent's hand uncrossing her legs (telling her it was good for circulation) and felt his hand going up and down her leg from the ankle to the knee.<sup>[112]</sup> At one point M.S. felt sick from the nitrous oxide and had to get up and go to the bathroom to throw up.<sup>[113]</sup> When she was in the bathroom M.S. noticed the top button of her sweater had been unbuttoned. Since she was in the middle of the dental work, with something in her mouth, she felt she had to return to the operatory to finish up.<sup>[114]</sup> Respondent also rested his hand on the skin of her stomach under her sweater.<sup>[115]</sup> The experience scared M.S. and she drove home as soon as she could after the appointment was done.<sup>[116]</sup> The appointment lasted 2½ to 3 hours.<sup>[117]</sup>

28. Later that same evening, M.S. went to the Hopkins Police to report the incident. She gave a tape-recorded statement to the police.<sup>[118]</sup> Even though Respondent had recorded the other times he gave M.S. nitrous oxide, he did not record the fact that he gave nitrous oxide to M.S. on this last appointment.<sup>[119]</sup>

29. Respondent usually, but not always, records his use of nitrous oxide on a patient in that patient's dental chart.<sup>[120]</sup> When he does record nitrous oxide use, he only notes the concentration level when it is unusual.<sup>[121]</sup> Not all dentists record the concentration level.<sup>[122]</sup> Respondent admits that the use of nitrous oxide should be recorded along with any untoward reaction.<sup>[123]</sup>

30. Approximately 50 to 58 percent of American dentists use nitrous oxide for pain or anxiety control. It is most commonly used for children and for oral surgery.<sup>[124]</sup> Commonly nitrous oxide is used until a local anesthetic like novocain takes effect, and is then reduced or turned off.<sup>[125]</sup> In Dr. Swift's opinion, failure to record the use of nitrous oxide in a dental chart falls below the standard of care in Minnesota.<sup>[126]</sup> Dr. Swift also believes that recording must be done in such a way that another dentist can determine the actual concentration of nitrous oxide used in the period of time that the gas was administered.<sup>[127]</sup>

31. Nitrous oxide has no adverse side effects on the body's circulatory system, so that a patient's legs do not need to be uncrossed while under sedation.<sup>[128]</sup> Nitrous oxide is a central nervous system depressant but is not normally a hallucinogen,

when used in normal concentrations, that would cause people to conjure up visions, unreal situations, or sexual hallucinations.<sup>[129]</sup> There is some data to the contrary, however.<sup>[130]</sup> At high concentrations sexual responses in females have been reported.<sup>[131]</sup> It is a mood elevating drug that induces euphoria.<sup>[132]</sup> Persons who remain awake and do not actually fall asleep under nitrous oxide are able to remember events that occurred during their sedation.<sup>[133]</sup> A side effect of a high concentration for a longer period of time is nausea and vomiting.<sup>[134]</sup>

#### Patient A.D.

32. On May 17, 1994, a 23-year-old woman named A.D. began seeing Respondent for dental treatment.<sup>[135]</sup> She was employed as a security guard at a casino.<sup>[136]</sup> She has a 2-year law enforcement degree.<sup>[137]</sup> Between then and July 22, 1994, Respondent scheduled A.D. for six appointments, four of which were for root canal work on one tooth.<sup>[138]</sup> Normally root canals take only two to three appointments.<sup>[139]</sup> The billing records show the use of nitrous oxide for A.D. only on June 7, 1994.<sup>[140]</sup>

33. On August 9, 1994, A.D. went in for an appointment late in the day to finish up the root canal work.<sup>[141]</sup> During the August 9, 1994, appointment Respondent gave her Novocain and nitrous oxide.<sup>[142]</sup> This was not recorded in her patient chart, however.<sup>[143]</sup> After A.D. had been in the dental chair about three hours Respondent told his employees to go home, leaving Respondent alone in the office with her.<sup>[144]</sup> This was unusual and caused employee K.M. to be concerned.<sup>[145]</sup> While she was under the effects of the nitrous oxide, A.D. believed Respondent did sexual things to her, like touching her breast.<sup>[146]</sup> A.D. tried to say no when this happened. Eventually she was able to take the nitrous oxide mask off to get up and leave the office.<sup>[147]</sup> A.D. never made a complaint to Respondent about his behavior, and the first time A.D. ever discussed Respondent's conduct with anyone was during the present investigation, six years later.<sup>[148]</sup>

34. Later, on August 24, 1994, when she thought there was something wrong with the tooth Respondent had treated on August 9<sup>th</sup>, A.D. called the Respondent's office for treatment but deliberately avoided an appointment with Respondent because she did not want to see him again.<sup>[149]</sup> Instead, she got an appointment with one of Respondent's associate dentists.<sup>[150]</sup>

35. During the Attorney General's investigation of this case, when Respondent was first asked by the investigator in March 2000 about A.D., Respondent stated that he did not recall her name.<sup>[151]</sup> At the hearing in this case Respondent admitted that he knew A.D., and also that he had a sexual affair with her in 1994 while she was a patient and when he was still married.<sup>[152]</sup> A.D. denies any affair or voluntary sexual relations with Respondent.<sup>[153]</sup>

#### Patient M.F.

36. In 1983, Respondent married J.J.H.<sup>[154]</sup>. They have four children together, a daughter born in 1984 (currently 16 years old), another daughter born in 1986 (currently 14 years old), a son born in 1991 (currently 9 years old), and a daughter born in 1993 (currently 7 years old).<sup>[155]</sup> During this marriage, Respondent and his wife moved from Minneapolis to a house in Eden Prairie.<sup>[156]</sup> One of the neighbors on their block in Eden Prairie was the family of M.F., a girl who was born on May 17, 1976.<sup>[157]</sup> During her senior year in high school M.F. began baby-sitting Respondent's children.<sup>[158]</sup>

37. On or about November 1, 1996, Respondent separated from his wife by moving out of their Eden Prairie house.<sup>[159]</sup> Their divorce, however, did not become final until about July 1999.<sup>[160]</sup>

38. M.F. had been hired by Respondent in the summer of 1995, and she worked in both the front office and as a dental assistant.<sup>[161]</sup> Because Respondent did free dental work for his employees, M.F. also became Respondent's patient on July 1, 1995.<sup>[162]</sup> Within a few weeks after separating from his wife, Respondent then age 46, began dating M.F., then age 20.<sup>[163]</sup>

39. Respondent's relationship with M.F. lasted until mid-1999, when they broke up.<sup>[164]</sup> While Respondent was dating M.F. she stayed overnight in his apartment quite often and kept some of her belongings there.<sup>[165]</sup> Respondent gave her a key to his apartment.<sup>[166]</sup> During their relationship Respondent drank alcohol, and M.F. related a number of instances when he drank to the point of intoxication, beginning at the time that he broke up with his wife.<sup>[167]</sup>

40. During the course of their relationship Respondent wrote prescriptions for controlled substance pain pills for M.F. that were neither recorded in her dental chart nor related to any dental work performed.<sup>[168]</sup> Respondent wrote a total of about 15-20 prescriptions for M.F. from 1995 to 1999.<sup>[169]</sup> However, only four of these prescriptions were recorded in her dental chart in connection with any dental treatment.<sup>[170]</sup>

41. Respondent's wrote the following unrecorded prescriptions for M.F.:

**Comparison of Pharmacy Records<sup>[171]</sup> and Dental Records<sup>[172]</sup> for M.F.**

<u>Date</u>	<u>Drug</u>	<u>Quantity</u>	<u>Pharmacy</u>
7/10/97	Endocet	12	Snyder
2/9/98	Endocet	20	Snyder
4/9/98	Endocet	20	Snyder
4/17/98	Oxycodone/APAP	20	Target
6/10/98	Oxycodone/APAP	20	Target
7/29/98	Roxicet	20	Walgreens

9/2/98	Sulfisoxazol	40	Target
1/6/99	Oxycodone/APAP	24	Target
1/28/99	Roxicet	24	Walgreens
2/12/99	Roxicet	24	Walgreens
3/9/99	Oxycodone/APAP	24	Target

42. Respondent does not always maintain records of the narcotic prescriptions he writes, or of the receipt and dispensing of free narcotic samples he receives in his practice.<sup>[173]</sup> He stated that the reason he fails to do so is that it's not a requirement.<sup>[174]</sup>

43. Another unrecorded prescription unrelated to any documented dental treatment was written for G.C. G.C. is a long-time dedicated employee of Respondent and a close friend who has done numerous personal favors for him.<sup>[175]</sup> The records indicate:

**Comparison of Pharmacy Records<sup>[176]</sup> and Dental Records<sup>[177]</sup> for G.C.**

<u>Date</u>	<u>Drug</u>	<u>Quantity</u>	<u>Pharmacy</u>
2/18/98	Endocet	20	Snyder

44. It is Dr. Swift's opinion that the standard of care for recording prescriptions in dental charts is that they are always noted with the name of the medication, the quantity prescribed, the frequency for the medication to be taken, and the rationale for the prescription.<sup>[178]</sup> Furthermore, he believes that it is below the standard of care for a dentist to prescribe a controlled substance to anyone (patient or employee) that is not in connection with any sort of dental procedure.<sup>[179]</sup> Dr. Swift also believes that Respondent's writing the unrecorded prescriptions for his girlfriend M.F. was below the standard of care in Minnesota because, with only one exception, they were all for controlled substance narcotics with high abuse potential.<sup>[180]</sup>

45. During Respondent's dating relationship with M.F. he would also use nitrous oxide recreationally with her in his office after work hours.<sup>[181]</sup> These sessions occurred at all three offices, weekly at times, and involved sexual activity.<sup>[182]</sup> One incident happened on Halloween night, 1997. That evening M.F., Respondent, and a friend of Respondent's named R.H. went out partying in costumes.<sup>[183]</sup> M.F. was dressed as a witch with a wig of long, black hair.<sup>[184]</sup> Respondent was driving that night, and on their way home afterward Respondent stopped at his Hopkins dental office.<sup>[185]</sup> Once there Respondent started using the nitrous oxide tanks in the operatory while R.H. and M.F. remained in the waiting area.<sup>[186]</sup> When M.F. went back to the operatory, Respondent had the nitrous mask on himself and then tried to force her into the dental chair and put a nosepiece on her.<sup>[187]</sup> After a struggle, M.F. got away and walked out,

after which they went home.<sup>[188]</sup> Later, Respondent told M.F. not to say anything about it, and also told her he was going to tell R.H. the same thing.<sup>[189]</sup>

46. When dental hygienist M.E.H. left the Hopkins office at the end of the day on Halloween (which was on a Friday that year), the office was cleaned, the nosepieces were taken off the nitrous oxide equipment for sterilization, the nitrous oxide tanks were put away, and all dental chairs put in the upright position.<sup>[190]</sup> The next morning, Saturday, when she came into work, M.E.H. saw one of the operatory chairs reclined, with dark synthetic hair fibers on it and on the floor.<sup>[191]</sup> She also discovered that the nosepiece was back on the nitrous oxide tanks and that on the tanks was the same kind of black fibers of wig hair she saw on the dental chair.<sup>[192]</sup> M.E.H. then reported what she had found to Dr. Mark Bradshaw, one of the associate dentists who was working that Saturday in the Hopkins office.<sup>[193]</sup> Dr. Bradshaw also saw Halloween wig hair around the nitrous oxide machine.<sup>[194]</sup> Both M.E.H. and Bradshaw also saw small burn holes on the dental chair headrest.<sup>[195]</sup>

47. Two other employees of Respondent, K.M. and P.B., observed that, at times when they came into Respondent's Eagan office in the morning, they would see evidence that someone had been using the nitrous oxide machine during the night.<sup>[196]</sup> Their observations included seeing the nitrous machine moved from the location where it had been left the night before, dental chairs being in a reclined position when they had been upright the night before, and the chair arms being moved from their normal location.<sup>[197]</sup> K.M., who worked in the Eagan office and helped order nitrous oxide supplies for that location, also noticed they seemed to be going through a lot of nitrous oxide. She told office manager G.C. to tell somebody to quit using it.<sup>[198]</sup>

48. In January, 1997, patient checks were discovered missing from Respondent's office.<sup>[199]</sup> The thefts were reported to the Hopkins police, who subsequently informed Respondent that his driver's license was recovered from the TCF bank in St. Louis Park, Minnesota, during an attempt to cash one of the missing checks.<sup>[200]</sup> M.F. had access to Respondent billfold at the time.<sup>[201]</sup>

49. M.F. eventually admitted to Respondent she was responsible for the thefts from his office.<sup>[202]</sup> She admitted taking patient checks and petty cash from the office, and stamps and other things from peoples' purses.<sup>[203]</sup> M.F. also admitted she and her cousin, Mark, were the ones who tried cashing Respondent's missing office checks at the TCF Bank drive through window.<sup>[204]</sup>

50. Shortly after M.F. admitted stealing from Respondent, Respondent and M.F. mutually agreed that M.F. would stop working for him.<sup>[205]</sup> M.F.'s employment with Respondent ceased in the fall of 1997, at which time they also stopped dating.<sup>[206]</sup> However, Respondent and M.F. resumed their dating relationship about a month later.<sup>[207]</sup>

51. M.F. worked for Alternative Billing Solutions ("ABS"), a billing company in Bloomington, Minnesota, before commencing her employment with Respondent.<sup>[208]</sup>

M.F. stole and forged checks from ABS while employed there and also stole and used credit cards.<sup>[209]</sup> She eventually repaid the money she stole.<sup>[210]</sup>

52. M.F. also had theft problems at her subsequent employment with Champion Air, where she was fired for stealing her supervisor's cell phone.<sup>[211]</sup> Her supervisor, Denise Athey, a station manager at the Minneapolis airport, noticed that her cell phone was missing on January 23, 2000.<sup>[212]</sup> Athey opened M.F.'s purse and found her stolen cell phone.<sup>[213]</sup> Athey discovered a business card belonging to M.F. inside the cell phone.<sup>[214]</sup>

53. As a result of this incident, M.F. was charged with receiving or concealing stolen property.<sup>[215]</sup> On August 24, 2000, she entered into an agreement to suspend prosecution, agreeing, in part: (1) not to commit a criminal or petty misdemeanor offense identical or similar to the charges therein; and (2) to pay prosecution costs of \$200.<sup>[216]</sup>

#### H.T.

54. In the summer of 1997, while Respondent was still dating M.F., he also began dating another young woman by the name of H.T.<sup>[217]</sup> They dated from that time until January, 1998.<sup>[218]</sup> H.T. never saw Respondent as a dental patient.<sup>[219]</sup> On two of his dates with H.T., Respondent took her to his Eagan dental office in the evening where he administered nitrous oxide to both of them recreationally.<sup>[220]</sup> Respondent also told H. T. that he had used nitrous oxide himself before.<sup>[221]</sup> On one of the two Eagan after hours office visits M.F. happened to witness Respondent going to the Eagan office late at night and followed him.<sup>[222]</sup> Because the door was locked she looked in the window and saw Respondent and H. T. using nitrous oxide together.<sup>[223]</sup> H.T. and Respondent were not fully dressed.<sup>[224]</sup> Becoming angry, M.F. called M.E.H., the office hygenist, to tell her that Respondent was in the office with a young woman and to ask her to come down and let her in.<sup>[225]</sup> M.E.H. told M.F. that she did not have a key and could not come down.<sup>[226]</sup> M.F. then bought a disposable camera to take pictures through the window.<sup>[227]</sup> H.T. remembered seeing flashes of light coming from the window one of the times she was in the office using nitrous oxide with Respondent.<sup>[228]</sup>

55. When earlier asked by the Attorney General's investigator whether H.T. was ever in his Eagan office in the evening hours, Respondent answered "I don't believe so."<sup>[229]</sup> Respondent now admits that on the two occasions he took H.T. to his office he played with the nitrous oxide tanks by placing the mask on his nose.<sup>[230]</sup> According to Respondent, though, he only playfully feigned turning on the nitrous oxide tanks.<sup>[231]</sup> When H.T. first was asked if she used nitrous oxide with the Respondent she denied it.<sup>[232]</sup>

56. In Dr. Swift's opinion the non-dental use of nitrous oxide by dentists on themselves is improper and dangerous to both their health and their professional ability to practice dental procedures.<sup>[233]</sup> Dr. Swift believes that self-administration of nitrous oxide by dentists constitutes conduct unbecoming a dentist because of the potential to

cause harm in such abuse.<sup>[234]</sup> In Dr. Swift's opinion it is below the standard of care for dentists to allow others to use nitrous oxide recreationally in their presence.<sup>[235]</sup> Dr. Swift concluded that there is no reasonable explanation for any dentist "playfully" putting a nitrous oxide mask on himself or others without turning it on, and that it would be inappropriate to do so.<sup>[236]</sup>

#### Patient E.S.

57. On July 27, 1997, while Respondent was still dating M.F., he had a date with another young woman named E.S., who was also a current patient.<sup>[237]</sup> E.S. began seeing Respondent for dental treatment on May 7, 1997.<sup>[238]</sup> On July 27, 1997, she had a mid-day appointment for root canal work.<sup>[239]</sup> Because she experienced some pain during the appointment, Respondent gave her a prescription for pain pills which she filled afterward on the way to work.<sup>[240]</sup> She took one pill.<sup>[241]</sup>

58. Later that evening Respondent called E.S. at home and asked her out for a boat ride on Lake Minnetonka.<sup>[242]</sup> While she thought the call "a little odd," E.S. accepted the date "against my better judgment."<sup>[243]</sup> She was having problems with her boyfriend and was looking for an excuse to break up with him.<sup>[244]</sup>

59. When Respondent picked her up that evening he asked if she had her painkillers with her, and she replied, "yes".<sup>[245]</sup> On the date Respondent first stopped at a liquor store to get some beer.<sup>[246]</sup> They then drove to Lake Minnetonka and went out on jet skis, took Respondent's boat out on the lake, and had dinner at a restaurant. They drank alcoholic beverages and smoked cigars.<sup>[247]</sup> On the way back from dinner, after dark, Respondent anchored the boat where they could go swimming and tried to persuade E.S. to go skinny-dipping with him.<sup>[248]</sup> At one point Respondent took off his swimsuit while in the water, so that he was naked.<sup>[249]</sup> E.S. went swimming but kept her swimsuit on. After getting back on the boat, Respondent and E.S. kissed for approximately 15 to 30 minutes.<sup>[250]</sup> They did nothing more than kiss, and Respondent never forced himself upon her.<sup>[251]</sup> After kissing, Respondent and E.S. drove the boat back to the dock.<sup>[252]</sup>

60. M.F. was waiting for them at the dock and she confronted Respondent about going out with another woman.<sup>[253]</sup> M.F. was angry and yelled at the Respondent.<sup>[254]</sup> Respondent did not react to the confrontation, however. According to E.S. and M.F. Respondent was intoxicated.<sup>[255]</sup> Because E.S. did not want to drive home with Respondent, she got a ride with M.F.<sup>[256]</sup> E.S. never went back to Respondent for dental work again because she felt he "was not someone I would consider I could trust at that point."<sup>[257]</sup>

61. Respondent admitted both in the Attorney General's investigation and at the March, 2000, hearing in this case, that dentists dating patients is not a good idea.<sup>[258]</sup> Respondent also admits it was not a good idea when he dated his patients M.F. and E.S.<sup>[259]</sup>

62. In Dr. Swift's opinion it is below the standard of care in Minnesota for a dentist to date a patient who is under active treatment by that dentist.<sup>[260]</sup>

### Use of Alcohol

63. Although Respondent drinks socially,<sup>[261]</sup> he has never consumed, or been under the influence of, alcohol while at work. No patient or employee has ever made a comment that they smelled alcohol on Respondent's breath during working hours.<sup>[262]</sup>

64. On the night of August 23-24, 1997, while H.T. was on a date with Respondent in his boat, Respondent was arrested for Boating While Intoxicated.<sup>[263]</sup> The arresting officer observed Respondent driving his boat on Lake Minnetonka at a speed exceeding the nighttime limit, with no white 360-degree light, and violating a slow "no wake" zone.<sup>[264]</sup> Respondent's eyes were red and watery, his speech slurred, his coordination off, and there was an odor of consumed alcoholic beverage coming from him. He was polite and cooperative.<sup>[265]</sup> Respondent failed the field sobriety test and the preliminary breath test.<sup>[266]</sup> After his arrest Respondent was tested on the Intoxilizer with a result of .12 blood alcohol content.<sup>[267]</sup> Respondent eventually plead guilty to careless watercraft operation, which was not an unusual disposition given his lack of previous alcohol related offenses.<sup>[268]</sup>

65. Respondent underwent a court-ordered alcohol assessment with a chemical dependency counselor as a condition of his plea agreement.<sup>[269]</sup> The counselor concluded, according to his report dated September 25, 1997, that Respondent had "no apparent problem" in terms of a chemical dependency.<sup>[270]</sup> Respondent's 1997 boating citation was the first, and only, time he has been cited for the illegal operation of a boat or vehicle while under the influence of alcohol.<sup>[271]</sup>

66. Respondent's friend R.H. saw Respondent drunk once at a New Years Eve party, and also saw Respondent close to being drunk on other occasions.<sup>[272]</sup> One of those times was on Halloween night, 1997, when R.H. said that he could tell Respondent had had a few beers.<sup>[273]</sup> Generally Respondent's friends describe him as a moderate social drinker.<sup>[274]</sup>

67. On December 6-7, 1997, Respondent was out on a date with H.T. The two of them were drinking beer and both had too much to drink.<sup>[275]</sup> Respondent decided, because of his drinking and the watercraft conviction, to give his car keys to H.T.<sup>[276]</sup> However, H.T.'s driving caused an accident resulting in a rollover of Respondent's vehicle.<sup>[277]</sup> H.T.'s alcohol concentration that night tested at .17.<sup>[278]</sup> After this incident Respondent broke up with H.T., although he paid for an attorney to defend her against the drunk driving charges to which she ultimately pled guilty.<sup>[279]</sup>

### The Board Complaint

68. Respondent and M.F. continued their dating relationship until July 1999, when they permanently broke up.<sup>[280]</sup> At that time, Respondent told her he would not marry her and that they should each go their separate ways.<sup>[281]</sup> M.F. was unhappy

about the break up, but Respondent did not seem bitter or upset.<sup>[282]</sup> After Respondent ended their relationship, M.F. showed up unannounced at Respondent's current girlfriend's house and circled the neighborhood.<sup>[283]</sup> M.F. also tried breaking into Respondent's apartment in December, 1999.<sup>[284]</sup>

69. Respondent told M.F. several times "don't you dare go to the Board, I would make you look like you're a crazy woman. Nobody will testify, and I'll bring up everything you've done wrong."<sup>[285]</sup> This made M.F. feel that something was not right<sup>[286]</sup> so she called her friend, B.F., a dental hygienist, for advice on what to do.<sup>[287]</sup> B.F. advised M.F. to talk to her boss, Dr. Lingle, a respected local dentist.<sup>[288]</sup> M.F. then called Dr. Lingle and told him, in hypothetical terms and without mentioning Respondent's name, the things which she knew about Respondent.<sup>[289]</sup> Dr. Lingle advised her that she should call the Board of Dentistry with the information she had.<sup>[290]</sup> However, M.F. was nervous and hesitant about doing so.<sup>[291]</sup> At one point she decided not to go ahead with the complaint.<sup>[292]</sup>

70. On or about July 22, 1999, M.F., following the advice of Dr. Lingle and B.F., called the Board of Dentistry to file a complaint.<sup>[293]</sup> After that the Attorney General's office commenced an investigation at the request of the Board.<sup>[294]</sup>

71. After filing a complaint with the Board against Respondent on July 22, 1999, M.F. sought dental treatment from Respondent in early 2000.<sup>[295]</sup> She did so because she was being bothered by root canal work performed by another dentist, and she knew Respondent would see her on an emergency basis and she felt comfortable with Respondent.<sup>[296]</sup>

### The Rush Center Assessment

72. On July 25, 2000, Respondent self-referred himself, through the Board of Dentistry, to a multidisciplinary assessment program at the Rush Behavioral Health Center ("Rush Center") in Chicago, Illinois.<sup>[297]</sup> The purposes of the examination were to conduct a general psychiatric evaluation, examine reports of alleged inappropriate behavior, conduct an assessment of his risk for sexually dangerous behavior, assess for the presence of chemical abuse/dependency, perform a fitness for duty evaluation, and if indicated, render treatment recommendations.<sup>[298]</sup>

73. The Rush Center conducted its assessment with a team consisting primarily of three professionals: Dr. Stafford Henry, a board certified psychiatrist; Dr. Mark McGovern, a psychologist; and Dr. James Devine, a psychologist.<sup>[299]</sup> Dr. Henry is the medical director of the Multidisciplinary Assessment Program at the Rush Center. They collected their data from several sources including background information from Respondent himself, collateral information from other witnesses (including those suggested by Respondent), information from the Board of Dentistry including the Attorney General's investigative reports, clinical contacts with Respondent by team members, and the results of a MMPI-2 test and a MCMI-3 ("Millon") test taken at the Rush Center by Respondent.<sup>[300]</sup> A Dr. Vigdor performed a physical examination for Respondent.<sup>[301]</sup> Dr. Vigdor did not find any evidence of alcohol abuse by



77. Dr. Henry described paraphilia as a sexual disorder that is not otherwise specified. In the Respondent's case, Dr. Henry concluded that his touching body parts of women in the dental chair and sexual activity with women under the influence of nitrous oxide constituted a paraphilia.<sup>[311]</sup> He believes the Respondent has a narcissistic personality based upon his lack of concern about how his children would respond to his dating their baby-sitter, based upon his continuing to date her after firing her for dishonesty, and based upon his indignant response to Dr. Henry's recommendation that he not practice dentistry.<sup>[312]</sup> Dr. Henry based his antisocial personality disorder diagnosis on Respondent's admitted billing fraud in a prior stipulated order.<sup>[313]</sup> He based his finding of alcohol dependence on his drinking while with E.S. and E.T. and his father's admission to the team he had admonished Respondent about his use of alcohol.<sup>[314]</sup>

78. Dr. Henry is of the opinion that Respondent is not currently appropriate to practice dentistry with requisite safety.<sup>[315]</sup> Dr. Henry concluded that it was unsafe to allow the Respondent to practice due to his use of nitrous oxide and alcohol and because he presents a risk to female patients.<sup>[316]</sup> As stated more specifically in the Rush Center report:

In consideration of all the above factors, we are of the opinion, to a reasonable degree of medical and psychiatric certainty, **Dr. Rolfe is not currently appropriate to practice dentistry with requisite competency, safety and skill.** We are of the opinion, to the same standard, the presence of symptoms of several psychiatric conditions, including character pathology, substance abuse and paraphiliac behavior raise sufficient concern to question his judgment, competency and safety.<sup>[317]</sup>

All the members of the Rush Center team concurred in Dr. Henry's opinion.<sup>[318]</sup> The report did rely on some facts that were later shown to be inaccurate, namely that Respondent billed for services not rendered, that Respondent may have been responsible for the theft of a nitrous oxide tank from his office and that Respondent had been dating M.F. before his separation from his wife.<sup>[319]</sup>

#### Other Expert Opinion

79. Dennis Hogenson ("Dr. Hogenson") is a clinical psychologist in private practice. He received his Ph.D. in clinical psychology in 1971.<sup>[320]</sup> Dr. Hogenson reviewed and did a blind evaluation of the results of Respondent's psychological tests (i.e. the MMPI and Millon tests) from Rush.<sup>[321]</sup> Dr. Hogenson first met Respondent just before the hearing in this matter and he knew nothing about Respondent or the situation that caused him to review Respondent's test results.<sup>[322]</sup>

80. The MMPI is the most commonly used and most reliable personality test in existence today and is recognized by authorities in the field as being the standard for testing.<sup>[323]</sup> It was originally designed to measure ten clinical scales, but has been

revised to include a number of additional scales.<sup>[324]</sup> The Millon test measures Axis II behavioral characteristics.<sup>[325]</sup>

81. In Dr. Hogenson's opinion the traditional clinical scales of Respondent's MMPI test results were all within normal ranges.<sup>[326]</sup> Dr. Hogenson saw no characteristics or tendencies for character or thought disorders and opined that the test results: (1) failed to demonstrate clinical problems such as depression or anxiety; (2) reflected no indications of any type of sociological deficits; and (3) reflected no evidence of any type of sexual deviancy.<sup>[327]</sup> To the contrary, Dr. Hogenson believes Respondent's test results reflected the work of a rational test taker and someone free from unusual levels of anxiety, depression and character disorder tendencies.<sup>[328]</sup>

82. Dr. Hogenson also testified about Respondent's "McAndrews" score on the MMPI. The McAndrews score on the MMPI is a scale that measures personality characteristics commonly associated with addictive tendencies and alcohol or substance abuse.<sup>[329]</sup> Respondent's McAndrews score did not bear out any kind of diagnosis of alcoholism or chemical dependency.<sup>[330]</sup>

83. In Dr. Hogenson's opinion Respondent's Millon test results suggested some histrionic personality characteristics, but not an usually high level.<sup>[331]</sup> The rest of the clinical scales on this test, like those of the MMPI, were within normal ranges.<sup>[332]</sup> In evaluating the Millon test results as a whole, Dr. Hogenson would have difficulty in coming up with a diagnostic profile because most of the scales were within normal limits.<sup>[333]</sup>

84. Dr. Hogenson is certain of his opinions regarding Respondent's MMPI test results to a reasonable degree of psychological certainty.<sup>[334]</sup>

85. In Dr. Hogenson's opinion, Rush's Axis I diagnosis (Inhalant abuse/Rule out dependence; Alcohol dependence; Rule-out other substance abuse; Paraphilia not otherwise specified; Caffeine-related disorder) was not supported by Respondent's test results on either the MMPI or Millon tests.<sup>[335]</sup> Dr. Hogenson also disagrees with Rush's finding of narcissistic and anti-social features, traits for which he saw no evidence in the test results.<sup>[336]</sup> In Dr. Hogenson's opinion, Rush's conclusions were based on something other than Respondent's test results.<sup>[337]</sup>

86. Dr. Hogenson did not disagree with the Rush Center's reading of these validity scales, but only on how they might be interpreted.<sup>[338]</sup> Respondent had a high K score (a validity scale), indicating evasiveness and defensiveness.<sup>[339]</sup> But Dr. Hogenson does not think that this invalidates the results.<sup>[340]</sup> He agreed that it was legitimate for professionals with clinical data to discount Respondent's guarded MMPI and Millon test results accordingly.<sup>[341]</sup> Dr. Hogenson did not have access to the clinical data available to Rush.<sup>[342]</sup>

87. Dr. Hogenson agrees with Rush's conclusion that Respondent's test results did not reflect primary psychopathology in the traditional clinical scales apart from a tendency to avoid self-disclosure.<sup>[343]</sup>

88. Dennis A. Philander, M.D. (“Dr. Philander”) is a physician who practices in the field of psychiatry.<sup>[344]</sup> He has lived in Minnesota for 33 years.<sup>[345]</sup> Dr. Philander has been licensed to practice medicine in the State of Minnesota since 1971.<sup>[346]</sup>

89. Dr. Philander has worked in private practice in Minnesota.<sup>[347]</sup> He worked with the Minneapolis Clinic of Psychiatry and Neurology from 1974 to 1985.<sup>[348]</sup> Since then, he has worked on his own, with one or two associates.<sup>[349]</sup> He has been affiliated with North Memorial Medical Center since 1974 (where he is now the medical director of the crisis unit) and with Fairview University Hospital for the last four years.<sup>[350]</sup>

90. Dr. Philander has also acted as the Chief of Staff at the Golden Valley Health Center and as the Chief of Neurology at North Memorial Medical Center.<sup>[351]</sup> While at the Golden Valley Health Clinic, Dr. Philander worked in the professional evaluation unit which included evaluation of sexual addiction and chemical dependency.<sup>[352]</sup> Dr. Philander was the director of those units and performed both professional and chemical dependency assessments.<sup>[353]</sup> Professionals evaluated included physicians, nurses, dentists and clergy.<sup>[354]</sup>

91. Dr. Philander performed a psychiatric examination and evaluation of Respondent.<sup>[355]</sup> He saw Respondent on three different occasions, for a total of about six hours, recording and transcribing each of the interviews.<sup>[356]</sup> Dr. Philander’s examination included focusing on Respondent’s medical history and his entire background history (including his family, academic, religious, juvenile and recreational history). Dr. Philander considers a history “very important,” and standard operating procedure for a psychiatrist.<sup>[357]</sup> A person’s juvenile history is important in the context of making a diagnosis that someone has anti-social personality traits, as found by Rush.<sup>[358]</sup> Dr. Philander emphasized the importance of getting a thorough and accurate personal history because “[i]t is the cornerstone of trying to assess or determine what the person’s constellation of beliefs and his work ethics and his academic standings and his family affiliation, his station in society.”<sup>[359]</sup>

92. Dr. Philander believes that Respondent is not chemically dependent and does not show any traits towards chemical dependency or habituation or addiction.<sup>[360]</sup> Dr. Philander also found that Respondent did not meet any of the seven DSM-IV criteria for substance dependence.<sup>[361]</sup>

93. In Dr. Philander’s opinion, Rush’s diagnosis of Axis I, alcohol dependence has not been supported, and is below the psychiatric standard of care.<sup>[362]</sup> Dr. Philander believes that Respondent does not meet any of the criteria for an Axis I diagnosis of paraphilia, not otherwise specified.<sup>[363]</sup> Dr. Philander saw nothing in Rush’s report to support such a diagnosis.<sup>[364]</sup>

94. Dr. Philander did not find support for Rush’s Axis II diagnosis of narcissistic personality disorder.<sup>[365]</sup> He believes that Rush’s diagnosis of personality disorder, not otherwise specified “is not appropriate” and that Rush was simply “groping” for a diagnosis.<sup>[366]</sup>

95. With respect to Rush's Axis V. Global Assessment Functioning (or G.A.F.) score of 65 (G.A.F. scores range from 0 to 100, with 100 reflecting "superior functioning"),<sup>[367]</sup> which suggests Respondent has difficulty in social, occupational, and school functioning, Dr. Philander believes that Rush "did not define any single symptom" in support of such a diagnosis.<sup>[368]</sup> Dr. Philander assessed respondent a G.A.F. score of "85 to 90, if not 95," just about "near the maximum."<sup>[369]</sup>

96. Dr. Philander strongly disagrees with Rush's conclusions: (1) that "Respondent is not currently appropriate to practice dentistry with requisite competency, safety, and skill"; and (2) that "the presence of symptoms of several psychiatric conditions, including character pathology, substance abuse, and paraphiliac behavior, raise sufficient concern to question [Respondent's] judgment, competency and safety".<sup>[370]</sup>

97. The Respondent's patients and staff generally describe the quality of his dental work as very good. He is described as competent and a good technician.<sup>[371]</sup>

98. Respondent is currently under a Stipulation and Order from the Board placing conditions on his license.<sup>[372]</sup> On March 31, 1995, Respondent agreed to accept, and the Board adopted, a Stipulation and Order which placed conditions on Respondent's license to practice dentistry in the State of Minnesota on the grounds that Respondent had perpetrated billing fraud; had provided substandard diagnostic, operative, periodontal, and radiographic treatment to one or more of his patients; had failed to make or maintain adequate patient records; had failed to comply with current infection control guidelines; had permitted auxiliary staff to provide services beyond their legal scope; and had engaged in personal conduct which brought discredit to the dental profession.<sup>[373]</sup>

99. The Board did not, in its 1995 Stipulation with Respondent, request or otherwise order Respondent to note the concentration level of nitrous oxide he administers to patients.<sup>[374]</sup>

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

### **CONCLUSIONS**

1. The Board of Dentistry and the Administrative Law Judge have jurisdiction in this matter under Minn. Stat. §§ 150A.08 and 14.50.

2. The Complaint Committee of the Board gave proper notice of the hearing in this matter and all relevant substantive and procedural requirements of statute and rule have been fulfilled.

3. The Committee has the burden of proof in this proceeding and must establish the facts at issue by a preponderance of the evidence.<sup>[375]</sup>

4. Minn. Stat. § 150A.08 provides in part as follows:

Subdivision 1: **Grounds.** The board may refuse or by order suspend or revoke, limit or modify by imposing conditions it deems necessary, any license to practice dentistry or dental hygiene or the registration of any dental assistant upon any of the following grounds.

...

- (4) Habitual overindulgence in the use of intoxicating liquors;
- (5) Improper or unauthorized prescription, dispensing, administering, or personal or other use of any legend drug as defined in chapter 151, of any chemical as defined in chapter 151, or of any controlled substance as defined in chapter 152;
- (6) Conduct unbecoming a person licensed to practice dentistry or dental hygiene or registered as a dental assistant, or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board;

...

- (8) Any physical, mental, emotional, or other disability which adversely affects a dentist's, dental hygienist's, or registered dental assistant's ability to perform the service for which the person is licensed or registered;

5. Minn. Rule pt. 3100.6200 provides in part, as follows:

"Conduct unbecoming a person licensed to practice dentistry or dental hygiene or registered as a dental assistant or conduct contrary to the best interests of the public," as used in Minnesota Statutes, section 150A.08, subdivision 1, clause (6), shall include the act of a dentist, dental hygienist, registered dental assistant, or applicant in:

- A. engaging in personal conduct which brings discredit to the profession of dentistry;
- B. gross ignorance or incompetence in the practice of dentistry and/or repeated performance of dental treatment which fall below accepted standards;
- C. making suggestive, lewd, lascivious, or improper advances to a patient;

D. charging a patient an unconscionable fee or charging for services not rendered (applicable to dentists only);

6. That, as applied in this proceeding, the language in statute and rule prohibiting “conduct unbecoming” a licensed dentist is not unconstitutionally vague.

7. That the doctrine of laches does not preclude the allegations concerning M.S. and A.D. based upon Minnesota case law, the failure to demonstrate unfair prejudice, and considering the procedural due process protections afforded Respondent in this contested case proceeding.

8. The Committee has proved by a preponderance of the evidence that Respondent committed conduct unbecoming a dentist, or contrary to the best interests of the public, by unnecessarily resting his forearm on female patients’ chests, and by dating female patients M.F. and E.S. during their course of treatment in a manner bringing discredit to the profession, in violation of Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 A.

9. That the Complaint Committee has failed to prove by a preponderance of the evidence that the Respondent engaged in conduct unbecoming a dentist in providing dental services to patients A.D. and M.S.

10. The Committee has not proved by a preponderance of the evidence that Respondent habitually over-indulged in the use of intoxicating liquors in violation of Minn. Stat. § 150A.08, subd. 1(4); or in violation of the prohibition against conduct unbecoming a dentist in Minn. Stat. § 150A.08, subd. 1(6) or Minn. R. 3100.6200 A.

11. The Committee has proved by a preponderance of the evidence that Respondent improperly administered nitrous oxide to himself and others (M.F. and H.T.) for nondental purposes in violation of Minn. Stat. § 150A.08, subd. 1(5); and in violation of the prohibition against conduct unbecoming a dentist in Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 A.

12. The Committee has proved by a preponderance of the evidence that Respondent improperly or in an unauthorized manner prescribed a legend drug, chemical, or controlled substance in violation of Minn. Stat. § 150A.08, subd. 1(5) for M.F. and G.C.

13. The Committee has not proved by a preponderance of the evidence that Respondent improperly or in an unauthorized manner personally used a legend drug, chemical, or controlled substance in violation of Minn. Stat. § 150A.08, subd. 1(5).

14. The Committee has not proved by a preponderance of the evidence that Respondent has a mental, emotional, or other disability which adversely affects his ability to perform as a licensed dentist, within the meaning of Minn. Stat. § 150A.08, subd. 1(8).

15. The Committee has not proved by a preponderance of the evidence that Respondent failed to provide appropriate periodontal diagnosis and/or treatment in violation of Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200 B.

16. Minn. Rule pt. 3100.9600 subp. 2-10 provides as follows:

Subp. 2. **Dental records.** Dentists shall maintain dental records on each patient. The records shall contain the components specified in subparts 3 to 10.

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Subp. 4. **Patient's reasons for visit.** When a patient presents with a chief complaint, dental records shall include the patient's stated oral health care reasons for visiting the dentist.

Subp. 5. **Dental and medical history.** Dental records shall include information from the patient or the patient's parent or guardian on the patient's dental and medical history. The information shall include a sufficient amount of data to support the recommended treatment plan.

Subp. 6. **Clinical examinations.** When emergency treatment is performed, items A, B, and C pertain only to the area treated. When a clinical examination is performed, dental records shall include:

- A. recording of existing oral health care status;
- B. any radiographs used; and
- C. the facsimiles or results of any other diagnostic aids used.

Subp. 7. **Diagnosis.** Dental records shall include a diagnosis.

Subp. 8. **Treatment plan.** Dental records shall include an agreed upon written and dated treatment plan except for routine dental care such as preventive services. The treatment plan shall be updated to reflect the current status of the patient's oral health and treatment.

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Subp. 10. **Progress notes.** Dental records shall include a chronology of the patient's progress throughout the course of all treatment and postoperative visits. The chronology shall include all

treatment provided, clearly identify the provider by name or initials, and identify all medications used and materials placed.

16. The Committee has proved by a preponderance of the evidence that Respondent failed to make or maintain adequate dental records on each patient in violation of Minn. Stat. § 150A.08, subd. 1(6) and 13; Minn. R. 3100.6200 B; and Minn. R. 3100.9600 subp. 10 in that he failed to record the use of nitrous oxide for all patients and he failed to record all medications prescribed.

17. That under Minn. Stat. § 150A.08 subd. 8 the designated Board members may temporarily suspend a license without a hearing if the Board finds that the licensee has violated a statute or rule which the Board is empowered to enforce and continued practice by the licensee would create an imminent risk of harm to others.

18. That the designated Board members reasonably concluded that the licensee had violated a statute or rule and would create an imminent risk of harm to others based upon the evidence before them, including the Rush Center assessment.

19. That the Committee has proved violations of statute and rule in this proceeding but has not proved that Respondent's continued practice would create an imminent use of harm to others.

20. That it is appropriate to discipline the Respondent for the violations proved.

21. Any Findings of Fact that should more properly be termed Conclusions are adopted as such.

22. A citation to the transcript or exhibits in the Findings of Fact does not imply that all testimony or exhibits that support the finding have been cited.

23. These Conclusions are arrived at for the reasons set out in the Memorandum that follows and that is incorporated into these Conclusions.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

### **RECOMMENDATION**

IT IS HEREBY RECOMMENDED: that the Board of Dentistry rescind the temporary suspension of the dental license of William P. Rolfe and proceed to take disciplinary action.

Dated this 9<sup>th</sup> day of May, 2001.

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GEORGE A. BECK  
Administrative Law Judge

Reported: Kirby A. Kennedy & Associates, Transcript Prepared (Eleven Volumes).

**NOTICE**

Pursuant to Minn. Stat. § 14.62, subd. 1, the Board is required to serve its final decision upon each party and the Administrative Law Judge by first class mail.

**MEMORANDUM**

The Complaint Committee (“Committee”) of the Minnesota Board of Dentistry has brought this disciplinary action against the dental license of William P. Rolfe, D.D.S. (“Respondent”). Respondent’s license was temporarily suspended by the Board on August 16, 2000, pursuant to the special provisions of Minn. Stat. § 150A.08, subd. 8. Thereafter, this disciplinary proceeding was commenced. The Committee claims that Respondent engaged in conduct unbecoming a dentist; abused alcohol or other substances; improperly administered nitrous oxide to himself and others for non-dental purposes; improperly prescribed controlled substances and other medications; failed to maintain adequate dental records on each patient; and is unable to practice dentistry with reasonable skill and safety due to a mental, emotional or other disability.

The determination of the facts in this case involves some difficult judgments as to the credibility of witnesses. A good deal of the Respondent’s testimony was not adopted because it did not seem reasonable when compared to other evidence, because his testimony on the stand was not frank and direct and because an important consideration is that Respondent has a great deal to lose if this case is decided against him. For example, Respondent’s denial of the Halloween incident in the face of the discovery of wig hair the next day in the operatory does not seem reasonable. The record contains numerous examples of this failure to be completely forthright<sup>[376]</sup> and of his evasiveness<sup>[377]</sup>. For example, in responding to whether or not he asked H.T. to go skinny dipping, the Respondent replied that “that might have been suggested”. In responding to whether he was trying to encourage her to take her swimsuit off the Respondent replied that “that would seem perhaps to be suggested”.<sup>[378]</sup> In response to a question the Respondent indicated at one point that “generally I might have had that type of discussion.”<sup>[379]</sup> The Respondent’s evasiveness and his demeanor suggests that he was trying to minimize any adverse testimony rather than being candid. Respondent also changed his testimony in the course of the proceeding. At one point the Respondent admitted to having been intoxicated in the past after previously testifying otherwise.<sup>[380]</sup> Respondent told an investigator for the Attorney General’s Office that he did not take H.T. to his office, but testified otherwise at the hearing.<sup>[381]</sup>

Another factor playing an important role in judging the credibility of witnesses who testified on behalf of the Respondent was the witnesses relationship to Respondent. For example, G.C. is a long-time and very loyal employee of the Respondent and personal friend. She testified that she had never seen Respondent rest his arm on a patient's breastbone<sup>[382]</sup> even though almost all of the witnesses have observed this. R.H. corroborated the Respondent's version of what happened on Halloween night in 1997. However, R.H. has been a friend of the Respondent since high school and participates in social and athletic activities with Respondent. Their testimony was discounted due to their relationship with Respondent and the unreasonableness of their testimony when compared to other testimony.

Witness M.F., who testified against the Respondent, has credibility problems of her own. The record indicates that she has stolen from three employers. Additionally she has reason to be angry with the Respondent since he was dating other women at the same time he was dating her and the Respondent ultimately decided that he would not marry her. That M.F. has a jealous nature is suggested by her following Respondent to his Eagan office one evening when he was with another woman and her appearing uninvited at the apartment of the Respondent's present girlfriend. Nonetheless, most of M.F.'s testimony was believable because she did seem forthright and was able to supply considerable detail. It also appears that she was in some doubt about whether to file a complaint and sought advice from another dentist before doing so. This does not create a picture of someone so bent on revenge that she would fabricate extensive testimony about the Respondent.

Because of the credibility questions, however, the Administrative Law Judge generally relied upon M.F.'s testimony only where it was corroborated by other testimony. Generally, if a testimony of a witness is consistent and believable on the main facts and issue then that persons testimony can be believed, even if the witness may have fabricated at other times on other issues or even if the witness has a criminal history.<sup>[383]</sup> It would not be reasonable to disregard all of M.F.'s testimony due to her jealousy or stealing. However, where there is insufficient corroboration of her testimony, for example, in her testimony on Respondent's use of controlled substances or his excessive drinking, her credibility problems suggest that this testimony should not be relied upon.

The Complaint Committee first asserts that Respondent has engaged in conduct unbecoming a dentist or contrary to the best interests of the public by admittedly resting his forearm on the chest of female patients while performing dental work. Two of Respondent's employees questioned this practice after receiving complaints from patients. They expressed their concern to Respondent in a meeting, however, he indicated that he would continue with the practice. The Complaint Committee expert, Dr. Swift, testified that it is improper, under the standards in Minnesota, for a dentist to rest a forearm on the chest of either female or male patients. He testified that such contact is unnecessary because the dentist's body can be positioned and access to the oral cavity can be made without touching the patient's chest, particularly if the dentist's chair is elevated above the level of the patient, as it should be. Dr. Swift's testimony is reasonable and convincing.

The Respondent testified that he learned this practice in dental school. However, Dr. Larson, who teaches at the dental school stated that this was never taught as an accepted position and that students were warned that for female patients in particular, appropriate physical contact would only be from the clavicle up. A textbook submitted on behalf of the Respondent does not support his claim that this is a practice he learned in school. It does not show any position in which the forearm has contact with a patient's chest and specifically recommends against the eight o'clock position used by Respondent. Respondent also asserted that he used this position in order to minimize hip pain. However, he acknowledges that he has only recently experienced significant hip pain and yet has used this position since dental school. The record indicates that Respondent did not tell others, including staff or Dr. Henry, that he used the position to avoid hip pain.<sup>[384]</sup> He told Dr. Henry he used this position for efficiency.

Respondent's classmate, Dr. Erickson, testified that some physical contact with a patient's chest is inevitable for certain procedures. However, the record indicates that due to the height of the Respondent's dental chair, the contact between his forearm and a patient's breastbone area is more than incidental, but occurs with some regularity. The evidence presented by the Committee establishes that this practice is unnecessary and improper and constitutes conduct unbecoming a dentist and is not in the best interest of the public.

The Committee has not demonstrated, however, that occasionally placing dental instruments on a patient's bib instead of the tray is conduct unbecoming a dentist. Dr. Swift indicated that a practice of *regularly* placing instruments on a patient's chest is below the standard of care. However, the Committee only proved that the Respondent does this occasionally and only for a brief period of time. Both Dr. Erickson and Dr. Larson testified that this practice happens occasionally on a daily basis in dental offices.

The Complaint Committee has proven that the Respondent does not always have a dental assistant present when providing dental treatment. However, a preponderance of the evidence does not support Dr. Swift's opinion that the standard of care in Minnesota is that a dentist and a patient of the opposite sex are never left alone by themselves in the operatory. Dr. Larson, the Committee's expert, believes that a dental assistant should usually be present but not necessarily at all times. The record supports the conclusion that there are certain procedures which do not require a dental assistant. An employee of Respondent called by the Committee testified that an assistant is not needed for an entire root canal procedure.<sup>[385]</sup> Respondent does have a dental assistant present most of the time.

Two incidents of sexual misconduct by the Respondent are alleged by the Complaint Committee. It argues that this behavior constitutes conduct unbecoming a dentist and improper advances by the dentist. Both patients were under the influence of nitrous oxide when the alleged incidents occurred. The Administrative Law Judge feels compelled to consider this testimony with the Supreme Court's decision in *In re Wang*,<sup>[386]</sup> a dental license case, in mind. In that case the Supreme Court found that allegations of improper advances to three patients were not supported by substantial evidence in part because expert testimony regarding anesthetics used by the dentist

suggested that the complainants may have suffered transient hallucinations or dreams of a sexual nature.<sup>[387]</sup> Although the court acknowledged that the appropriate standard of proof was preponderance of the evidence, it went on to state:

“Even so, these proceedings brought on behalf of the state, attacking a person’s professional and personal reputation and character and seeking to impose disciplinary sanctions, are no ordinary proceedings. We trust that in all professional disciplinary matters, the finder of fact, bearing in mind the gravity of the decision to be made, will be persuaded only by evidence with heft. The reputation of a profession, and the reputation of a professional as well as the public’s trust are at stake.”<sup>[388]</sup>

There is contradictory evidence in the record concerning whether or not nitrous oxide can be a hallucinogen that might cause patients to imagine situations that have not in fact occurred. Dr. Swift flatly testified that it is not a hallucinogen and that persons are able to remember events under its influence. Dr. Philander, although not an expert on the effects of nitrous oxide, testified that his review of studies on the subject indicates that it is well documented that very short lived and abbreviated hallucinatory experiences can be caused by nitrous oxide.<sup>[389]</sup> The state of the record together with the caution suggested by the opinion *In re Wang* requires a careful examination of testimony about events that occurred when the witness was anesthetized by nitrous oxide.

Although A.D.’s testimony appeared straightforward, it does not satisfy the tests set out *In re Wang* for several reasons. One reason was her own description of her state of consciousness. A.D. acknowledged that while she was under the influence of nitrous oxide it was “kind of a dream atmosphere that I was seeing.”<sup>[390]</sup> She observed that “it was very difficult to see events happening, to know what was being done to me.”<sup>[391]</sup> At one point A.D. described “hallucinating” and “seeing stars” while being under the influence of nitrous oxide.<sup>[392]</sup> Additionally, there are discrepancies which caused the fact finder to question whether her testimony constitutes evidence “with heft”. For example, although A.D. recalled that Respondent sent his employees home immediately when she arrived,<sup>[393]</sup> one assistant testified that A.D. was in the chair three hours before the assistant left for the day.<sup>[394]</sup> The only entry for nitrous oxide for A.D. was on June 7, 1994 rather than August 9, 1994, the date on which she alleges she was assaulted. On June 7, 1994 she had the last appointment at 4:00 p.m. according to records. On August 9, 1994 her appointment is listed as 2:30 p.m. with two more appointments after her at 3:30 p.m. and 4:30 p.m.<sup>[395]</sup> It appears likely that the last two appointments did show up on August 9, 1994.<sup>[396]</sup> Another reason for according less weight to this testimony is that A.D. never reported this assault to anyone even though she had law enforcement training. An additional contradiction in the testimony is that Respondent admits an affair with A.D. while she denies it. Yet, the evidence indicates that Respondent told people about this affair shortly after it happened.<sup>[397]</sup> Considering all of these factors, it can not be concluded that this evidence meets the tests set out in *In re Wang*, especially when the serious acts alleged by A.D. are inconsistent with the acts described in other testimony in this proceeding.

The testimony of M.S. relates less serious allegations and is supported by a contemporary police report. M.S.'s testimony at the hearing was straightforward and sincere. The facts she testified to established that Respondent uncrossed her legs, that the top button of her sweater became unbuttoned and that Respondent rested his hand on the skin of her stomach. But in *In re Wang*, the court found that similar allegations may have been the result of "ordinary touchings when removing a bib, the leaning or reaching over a patient, the necessary patting or rubbing of a patient's hand or arm, along with the after effects of an anesthetic, (that) could also have been misunderstood."<sup>[398]</sup> In light of the Supreme Court's direction, it is difficult to conclude that the behavior which M.S. believes occurred satisfies the evidentiary standard set out in *In re Wang*. It therefore can not be said to constitute conduct unbecoming a dentist.

The Complaint Committee also asserts that it has demonstrated conduct unbecoming a dentist by the events that occurred when Respondent dated patients M.F. and E.S. The Committee notes that the Respondent has admitted that dating patients is a bad idea. The record supports this conclusion. However, this admission does not mean that it also amounts to unprofessional conduct for a dentist. The consideration of the Respondent's conduct in regard to M.F. is complicated by the fact that she was a patient only by virtue of also being an employee and by the fact that the Respondent had a long term relationship with her. The incident with patient E.S. is clearer. The Respondent called her for a date on the evening on the day he had done root canal work for E.S. He had given her a prescription that day for a controlled substance for pain in connection with the dental work. On the date the Respondent first stopped at a liquor store to get some beer. They also had dinner at a restaurant at Lake Minnetonka and the record indicates that the Respondent drank a good deal of beer. He removed his swimming suit while swimming from his boat in an effort to persuade E.S. to go skinny dipping with him. An angry confrontation with M.F. ensued upon their return to the dock. E.S. never returned to the Respondent for dental work because she felt she could not trust him.

Dr. Swift testified that any dating of a patient under active treatment by a dentist is below the standard of care in Minnesota and would constitute conduct unbecoming a dentist. The Respondent points out there is no specific support for this position in statute or rule or literature. Nonetheless, for the reasons set out under "Conduct Unbecoming a Dentist" below, Respondent's conduct in dating E.S. clearly is contrary to the best interests of the public, brings discredit to the profession of dentistry and is appropriately found to be conduct unbecoming a dentist.

The Complaint Committee has not sustained its burden to show that Respondent habitually overindulged in the use of intoxicating liquors. That is not to say that the record lacks examples of Respondent having problems involving alcohol. He was arrested for boating while intoxicated and convicted of careless watercraft operation after a .12 blood alcohol test. The record also indicates several social occasions where the Respondent had too much to drink. However, it appears that most of the time the Respondent is a moderate social drinker. The record shows that Respondent's personal physician, who has evaluated pilots for chemical dependency for 20 years, has never seen any indications of alcohol abuse by the Respondent. A court ordered

alcohol assessment after the boating incident resulted in a report from a chemical dependency counselor that concluded that Respondent had no apparent problem in terms of chemical dependency. Dr. Hogenson and Dr. Philander both felt that any diagnosis of alcohol dependence was not supported. Dr. Vigdor at the Rush Center saw no physical evidence of alcohol dependence.

It appears that Dr. Henry's diagnosis in that regard was based upon a description of Respondent's drinking with E.S. and E.T. and his father's admission that he had admonished Respondent about the use of alcohol. The record indicates however that Respondent's father was responding to Respondent's arrest. The evidence shows that the Respondent did have too much to drink with E.S. and E.T. But the evidence is not sufficient to support a conclusion that Respondent *habitually* overindulged. Furthermore, the opinions of Dr. Saliterman, Dr. Hogenson and Dr. Philander and the reasons supporting those opinions carry more weight than Dr. Henry's conclusion on alcohol dependence.

The evidence indicates that it is more likely than not that Respondent improperly administered nitrous oxide to himself and others for non-dental purposes. H.T., a witness who dated Respondent for several months at the end of 1997, described two dates in which Respondent took her to his Eagan dental office and administered nitrous oxide for non-dental purposes to both of them. Sexual activity was also involved. M.F. witnessed one of these occasions. Although H.T. had earlier denied using nitrous oxide with Respondent, her testimony at the hearing was sincere and direct. She has nothing to gain by providing false testimony. Respondent's assertion that he merely placed the nitrous oxide equipment on his face in a playful manner at his Eagan office after hours with H.T. is not credible.

The testimony of M.F. that she and Respondent used nitrous oxide recreationally in his office after work hours on a number of occasions involving sexual activity is credited over the denial of Respondent and the testimony of his friend R.H. M.F.'s testimony is supported by the witnesses who found black wig hair in an operatory at the Hopkin's office on the day after Halloween in 1997. Other employees had observed indications of the use of nitrous oxide after hours at the Eagan office. The Committee has established by a preponderance of the evidence that Respondent improperly administered nitrous oxide to himself and others for non-dental purposes.

Respondent admitted that he wrote at least 11 prescriptions for controlled substances for M.F. which were not recorded in her dental chart. The dates of the prescriptions do not correspond to any dental treatment provided to M.F. M.F. testified that they were not written in connection with dental work. The expert testimony of Dr. Swift is that it is below the standard of care for a dentist to prescribe a controlled substance to a patient or employee not in connection with a dental procedure. The record is clearly adequate to support the conclusion that Respondent improperly prescribed a controlled substance.

The Committee also argues that Respondent improperly used a chemical or controlled substance. This is based upon the general testimony of M.F. that

Respondent used some of the pills that he prescribed for M.F. In light of the non-specific nature of the testimony as well as a lack of corroboration of M.F.'s assertions it can not be concluded that, in light of the Respondent's denial, that it is more likely than not that this occurred within the meaning of *In re Wang*. The Committee also asserts that Respondent use of nitrous oxide is an improper use of a chemical, however, since this conduct is covered more specifically in statute or rule as discussed above it is more appropriately considered in that regard.

The Complaint Committee argues that the Rush Center assessment of Respondent supports a conclusion that Respondent has a mental, emotional or other disability adversely affecting his ability to perform as a licensed dentist. Dr. Henry's ultimate opinion was that the Respondent was not currently appropriate to practice dentistry with requisite competency, safety and skill due to the presence of several psychiatric conditions. The Complaint Committee points out that the Rush Center used a multi-disciplinary team approach and that each expert concurred in the opinion.

However, based upon a consideration of the record as a whole, the opinions of Respondent's experts, Dr. Hogenson and Dr. Philander, deserve more weight in regard to this issue than that of the Rush Center. The parties appear to agree that the MMPI and Millon tests do not reflect any primary psychopathology in the traditional clinical scales apart from a tendency to avoid self-disclosure. In Dr. Hogenson's opinion the test results show no character or thought disorders, clinical problems such as depression or anxiety, no sociological deficits and reflected no evidence of sexual deviancy. The Rush Center discounted the test results because it believed that the validity scale in the tests showed that Respondent had a distinct tendency toward avoiding self disclosure and that therefore, the validity of the test results was questionable. On the contrary, Dr. Hogenson believes that the Respondent's score on the validity scale is not uncommon for persons taking such tests under similar circumstances. He concludes that the "K scale" results do not invalidate the information obtained from the MMPI and the Millon tests. In Dr. Hogenson's opinion the diagnosis arrived at by the Rush Center were based on something other than test results.

The methodology employed in the Rush Center assessment is troubling in some respects. The Center appears to confuse its appropriate role by indicating, in regard to the use of nitrous oxide, that "we are of the opinion, to a reasonable degree of medical and psychiatric certainty, the evidence overwhelmingly supports the claim that Respondent regularly self-administered this substance"<sup>[399]</sup> It would not be appropriate to find facts to a reasonable degree of medical and psychiatric certainty. It would be appropriate rather to apply this standard in formulating an opinion based upon the facts assumed to be true. This suggests some uncertainty on the part of the Center as to its role. Additionally, the report describes the characteristics of individuals with conditions such as narcissism or anti-social traits, then labels Respondent as having these disorders, with the implication being that he exhibits those characteristics described. This short cut avoids a more thoughtful assessment based upon the collateral data.

It is likely that Respondent was evasive in interviews at the Rush Center as he was in this hearing. The report described the Respondent as "deceitful, dishonest and

duplicitous. His answers were often non-responsive, evasive and/or not believed.”<sup>[400]</sup> It seems clear that little of what Respondent said was believed. Because the Rush Center discounted the test results, their ultimate opinion was necessarily based upon the collateral data supplied. It accepted most, if not all, of the information supplied to it critical of Respondent as being true. Subsequently, some of those facts were found not to be true. And, some of the facts relied upon by the Rush Center were not proved by a preponderance of the evidence in this proceeding. The assessment must be reevaluated in light of the facts proved in this hearing.

The rationale supplied in the record for the conclusions arrived at by the Rush Center is not compelling. In his testimony Dr. Henry stated that the finding of paraphilia was based upon the Respondent touching body parts of women in the dental chair and sexual activity with women under the influence of nitrous oxide. As is discussed above, the record does not support the actions alleged in regard to M.S. and A.D. within the meaning of *In re Wang*. Dr. Henry’s conclusion that Respondent has a narcissistic personality was based upon what Dr. Henry thought was the Respondent’s lack of concern about how his children would respond to his dating their babysitter, upon his continuing to date her after firing her for dishonesty and based upon his indignant response to Dr. Henry’s recommendation that he not practice dentistry. The anti-social personality diagnosis was based on billing fraud covered in a prior stipulated Order and not a part of this proceeding. Finally, the finding of alcohol dependence was based upon his drinking with E.S. and E.T. and his father’s admission that he had admonished his son about the use of alcohol. The reasons given by Dr. Henry do not provide strong support for his diagnosis.

Dr. Philander, a psychiatrist in private practice in Minnesota since 1971 has experience in the assessment of professionals, including evaluation of sexual addiction and chemical dependency. He interviewed the Respondent on three different occasions for a total of six hours. He looked at Respondent’s medical history and his entire background history including his family, academic, religious, juvenile and recreational history. He did not find any indication of chemical dependency. He did not find any support for a diagnosis of narcissistic personality disorder. Based upon his examination he disagrees with the Rush Center conclusion that the Respondent has symptoms of several psychiatric conditions including character pathology, substance abuse, and paraphiliac behavior. He strongly disagrees with the conclusion that Respondent is not currently appropriate to practice dentistry with requisite competency, safety and skill. Considering Dr. Philander’s experience and expertise as well as the comprehensive nature of his evaluation and based upon the prior discussion of the Rush Center assessment, it seems more likely than not that Dr. Philander’s opinion is more accurate. Based upon that opinion, the record indicates that Respondent does not have a disability affecting his ability to perform as a licensed dentist.

Finally, the Complaint Committee asserts that Respondent failed to make or maintain adequate dental records on each patient. The Committee attempted to prove a number of violations related to a lack of diagnosis or of a treatment plan.<sup>[401]</sup> However, Respondent’s testimony demonstrated that either the Committee’s expert was unable to interpret his notes or the treatment given made the diagnosis evident.<sup>[402]</sup> The

Respondent's charting was not shown to differ much from other dentists in his office. The record indicates, and the Respondent admits, that he does not always record the use of nitrous oxide in the patient's dental chart. He has also admitted that he wrote a number of control substance prescriptions that were not recorded in the dental chart. The expert testimony of Dr. Swift indicates that failure to record the use of nitrous oxide or the prescription of medication falls below the standard of care in Minnesota for dentists. It must be concluded that Respondent failed to maintain adequate dental records.

### Conduct Unbecoming a Dentist

Minnesota Statutes § 150A.08, subd. 1(6) provides that the Board may impose discipline on a licensed dentist for "conduct unbecoming a person licensed to practice dentistry ... or conduct contrary to the best interest of the public, as such conduct is defined by the rules of the board". The statutory phrase "conduct unbecoming" is defined in Minnesota Rule 3100.6200, which states in relevant part:

"Conduct unbecoming a person licensed to practice dentistry or dental hygiene or registered as a dental assistant or conduct contrary to the best interests of the public," as used in Minnesota Statutes, section 150A.08, subdivision 1, clause (6), shall include the act of a dentist, dental hygienist, registered dental assistant, or applicant in:

- A. engaging in personal conduct which brings discredit to the profession of dentistry;
- B. gross ignorance or incompetence in the practice of dentistry and/or repeated performance of dental treatment which fall below accepted standards;
- C. making suggestive, lewd, lascivious, or improper advances to a patient; ...

Respondent argues that the prohibition on "conduct unbecoming" a dentist found in Minn. Stat. § 150A.08, subd. 1(6) is unconstitutionally vague as applied to his dating of patients. According to Respondent, the Committee's attempt to discipline him for dating and having sexual relationships with his patients on the grounds that it constitutes "conduct unbecoming" a dentist violates his constitutional due process rights. Respondent contends that the phrase "conduct unbecoming" is so vague as to deny him notice or a reasonable opportunity to know that his conduct in dating patients is subject to disciplinary action. And Respondent points out that there is no statute or rule promulgated by the Board that explicitly prohibits dating or sexual relations between a dentist and patient. Accordingly, Respondent asserts that he should not be disciplined for such conduct.

The Committee maintains that while dating patients is not *per se* wrong, dating patients in the irresponsible and harmful manner engaged in by Respondent with E.S. and M.F. constitutes conduct unbecoming a dentist or "personal conduct which brings

discredit to the profession”. Moreover, the Committee argues that both the courts and the Board have successfully applied the rule against conduct unbecoming in other cases. In *Matter of Schultz*<sup>[403]</sup>, for example, the statutory phrase “conduct unbecoming” was specifically applied in the case of another dentist’s sexual misconduct toward female patients. The Minnesota Court of Appeals held in that case that the Board was “uniquely able to determine” what constituted conduct unbecoming a dentist.<sup>[404]</sup>

In the instant matter, the Committee contends that Respondent’s date with E.S. reflected a complete lack of professional discretion and brought “discredit to the profession of dentistry”. The Committee points out that Respondent asked E.S. out for drinks on the same day he prescribed narcotic pain pills for her; Respondent asked E.S. if she had the pills with her when he picked her up; Respondent took off his swimsuit; and Respondent drank enough beer that he appeared intoxicated to E.S. and M.F. and E.S. did not allow him to drive her home. The Committee also asserts that Respondent engaged in personal conduct that brought discredit to the profession of dentistry during his dating relationship with M.F. In particular, the Committee cites to the numerous narcotic prescriptions Respondent wrote for M.F. over the course of their relationship, and Respondent’s recreational use of nitrous oxide with M.F. in his offices after hours.

Neither an administrative agency, such as the Board, nor an administrative law judge may declare a statute unconstitutional as that power is vested in the judicial branch.<sup>[405]</sup> But like courts, Administrative Law Judges must interpret and apply statutes and rules in a manner that does not violate our constitutions.<sup>[406]</sup> Under both the United States and Minnesota Constitutions, statutes and rules must meet due process standards of definiteness.<sup>[407]</sup> In order to satisfy due process, laws must give fair warning to an individual of the conduct prohibited. More precisely, the vagueness doctrine requires “that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited.”<sup>[408]</sup> A statute is void due to vagueness if it defines the forbidden or required act in terms so vague that individuals must guess at its meaning, or it defines an act in a manner that encourages arbitrary and discriminatory enforcement.<sup>[409]</sup> If persons “of common intelligence” must speculate as to a statute’s meaning, the statute is impermissibly vague.<sup>[410]</sup>

In a case involving disciplinary action against optometrists’ licenses, the Minnesota Supreme Court considered whether “unprofessional conduct”, as a ground for discipline, was vague and an unconstitutional delegation of power to the board.<sup>[411]</sup> Minn. Stat. § 148.57, subd. 3, governing regulation of the practice of optometry, provided that the board could revoke or suspend the license of any practitioner guilty of “unprofessional conduct”. The court concluded that the phrase “unprofessional conduct” was not unduly vague and explained:

The legislature need not enumerate what specific acts or omissions constitute unprofessional conduct since the phrase “unprofessional conduct” itself provides a guide for, and a limitation upon, the exercise by the board of its power to revoke a practitioner’s license.<sup>[412]</sup>

In concluding that the phrase “unprofessional conduct” was sufficiently definite, the court stated that the legislature can not be expected to forbid specifically all improper practices likely to occur.<sup>[413]</sup>

The Administrative Law Judge is persuaded, based upon the rationale articulated in *Reyburn* and the successful application of the prohibition on “conduct unbecoming” in other cases, that the phrase is not impermissibly vague as applied in this case. Moreover, the phrase is further defined in the Board’s rules. The Committee is not arguing that any dating of a patient by a dentist is conduct unbecoming a dentist, even though Dr. Swift’s testimony was to that effect. The statute and rules do not provide specific notice to dentists that dating patients is flatly prohibited, as is the case for physicians. However, when applied to the facts of this case, the Administrative Law Judge concludes that the Committee has demonstrated, by a preponderance of the evidence, that Respondent did engage in conduct unbecoming a dentist. Specifically, by improperly placing his forearm on female patients’ chests and by dating female patients during the course of their treatment *in a manner bringing discredit to the profession*, Respondent violated Minnesota Statute § 150A.08, subd. 1(6) and Minnesota Rule 3100.6200 A. Respondent knew or should have known that such personal behavior amounts to conduct unbecoming a dentist.

### Standard of Proof

In professional disciplinary proceedings, such as this one, the Committee bears the burden of proof and must establish the facts at issue by a preponderance of the evidence.<sup>[414]</sup> This standard of proof applies to all contested cases unless a constitutional provision, statute, or case law requires the application of an alternative standard.<sup>[415]</sup> In license disciplinary proceedings involving dentists, no statute or case law requires a different standard of proof.

Respondent asserts, however, that constitutional due process and equal protection require the use of a heightened standard of proof in this matter. Respondent maintains that because his license to practice dentistry and his livelihood are at stake, due process requires that the Committee prove its case by a clear and convincing standard of proof. In addition, Respondent contends that, since a higher standard of proof is required in attorney disciplinary proceedings, use of the lower preponderance standard in non-attorney disciplinary proceedings violates equal protection. In support of his arguments, Respondent has cited to several non-Minnesota cases in which courts have held that constitutional due process and/or equal protection require that the standard of proof in license disciplinary proceedings be clear and convincing.<sup>[416]</sup>

In *In re Wang*<sup>[417]</sup>, the Minnesota Supreme Court confirmed the application of a preponderance of the evidence standard in professional licensing proceedings involving disciplinary action against a licensed dentist. In so doing, the court noted that no different standard of proof appeared to be required by statute or case law, and the parties had not claimed otherwise.<sup>[418]</sup> The court, however, admonished finders of fact in license disciplinary cases to bear in mind the gravity of the decision to be made and to be persuaded only by “evidence with heft”.<sup>[419]</sup>

Two years later, the Minnesota Court of Appeals addressed the constitutionality of applying the preponderance standard to non-attorney licensing matters in *In re Ins. Agents' Licenses of Kane*<sup>[420]</sup>. In that case, the insurance agents argued that application of the preponderance of the evidence standard violated equal protection since their licenses could be revoked pursuant to a lower standard of proof, while attorneys' licenses could only be revoked upon a showing of clear and convincing evidence of misconduct. The court rejected the agents' equal protection arguments based on the unique nature of attorney disciplinary hearings, society's heightened interest in the outcome of attorney discipline, and the fact that the legal profession is much more subject to accountability because discipline lies with the judiciary.<sup>[421]</sup> The court found that these distinctions provided a rational basis for employing the clear and convincing standard in attorney licensing proceedings and the preponderance of the evidence standard in other licensing proceedings.<sup>[422]</sup>

And in *In re Medical License of Friedenson*<sup>[423]</sup>, the Minnesota Court of Appeals held that the preponderance of the evidence standard applies to disciplinary proceedings against a licensed medical doctor. Noting that the statute governing the Board of Medical Practice's discipline of medical doctors is silent as to the standard of proof, the court applied the preponderance standard pursuant to Minnesota Rules 1400.7300, subp. 5.<sup>[424]</sup>

In light of the cases discussed and the fact that the statute governing this disciplinary proceeding is silent as to the standard of proof, the Administrative Law Judge concludes that the proper standard of proof to be applied in this matter is the preponderance of the evidence. Yet, the ALJ is mindful of the admonishment in *Wang* that finders of fact in license disciplinary cases bear in mind the gravity of the decision to be made and be persuaded only by "evidence with heft".<sup>[425]</sup> The findings made here have been adopted applying these standards.

#### "Stale Allegations" and the Doctrine of Laches

Respondent argues that due process and the doctrine of laches precludes taking disciplinary action against his license based on remote allegations of misconduct. Respondent contends that he is unfairly being forced to defend against nine year old allegations of sexual misconduct by M.S. and six year old allegations of sexual assault by A.D. Respondent maintains that, as a busy dentist who sees hundreds of patients annually, it is unfair to expect him to recall specific facts from nine and six year old dental appointments. Respondent also claims that he has been unfairly prejudiced as neither woman was subject to cross-examination at or near the time of their alleged assaults. And, Respondent points out that both M.S. and A.D. had difficulty remembering facts regarding the alleged assaults.

The Committee argues that the doctrine of laches is inapplicable as a defense against the state when the state is acting in its sovereign capacity.<sup>[426]</sup> Because the Board is acting in its sovereign capacity to regulate the dental profession for the protection of the public, the Committee maintains that the equitable doctrine of laches does not apply in this proceeding. Alternatively, the Committee asserts that because

Respondent has failed to show unfair prejudice as a result of the delay, the remote allegations at issue should be considered.

Application of the doctrine of laches depends on whether there has been such an unreasonable delay in asserting a known right, resulting in prejudice to others, as would make it inequitable to grant the relief prayed for.<sup>[427]</sup> When the state seeks to revoke professionals' licenses, laches will seldom be found as a matter of public policy unless the licensee has been unduly prejudiced.<sup>[428]</sup>

In *Fischer v. Independent School Dist. No. 622*<sup>[429]</sup>, an elementary school principal was discharged for sexual misconduct with a student based on events that were over 12 years old. The school principal claimed he was deprived due process by the remoteness of charges, the resulting loss of relevant evidence, and impeachment of witnesses' memories. The court held that the remoteness of the allegations did not result in a denial of due process to the principal. The court pointed out that there is no limitations period in the statute governing teacher terminations. And, given the serious nature of the offense and the lack of any showing that the board unduly delayed in bringing its action after it had received knowledge of the alleged conduct, the court concluded the incident was not too remote in time to be considered.<sup>[430]</sup> Moreover, the court found that the principal had sufficient procedural due process protections afforded him at the hearing, including an impartial hearing examiner and the opportunity for cross-examination, to ensure that the remoteness of the allegations did not amount to unfair prejudice.<sup>[431]</sup>

Likewise, in an attorney disciplinary case<sup>[432]</sup>, the Minnesota Supreme Court rejected an attorney's motion to dismiss based on an alleged 5 ½ year delay in the Board's investigation where the attorney failed to show prejudice. The court explained that unless the attorney had been unfairly prejudiced by the delay, it would not be in the public interest to dismiss a disciplinary hearing because of failure to prosecute promptly. The court stated that a fundamental goal of every disciplinary action is protection of the public.<sup>[433]</sup> And requiring a showing of prejudice before dismissing a disciplinary action for unreasonable delay is consistent with that goal.<sup>[434]</sup>

In the instant matter, there is no evidence that the Committee engaged in undue delay. Instead, the record demonstrates that the Committee first learned of M.S.'s and A.D.'s allegations during the course of its investigation of Respondent over the winter-spring of 1999-2000. The Committee began this enforcement action in the summer of 2000 and filed the Notice of Hearing, which gave full notice of the sexual misconduct allegations, on August 25, 2000. The Administrative Law Judge concludes that the Committee did not delay in bringing disciplinary action against Respondent once it learned of the sexual misconduct allegations at issue.

Moreover, Respondent has failed to show that he has been unfairly prejudiced by having to defend against the allegations of M.S. and A.D. The inability of M.S. and A.D. to recall certain facts or details surrounding the alleged assaults is insufficient to establish unfair prejudice where Respondent had the opportunity to cross-examine both women and question their credibility. If anything, M.S.'s and A.D.'s lack of memory

hurts the Committee more than Respondent as it is the Committee that bears the burden of proof in this matter. And, in fact, it is concluded in this case that the allegations concerning A.D. are not proved by a preponderance of the evidence when the Supreme Court's admonitions *In re Wang* are considered. Even though the incident with M.S. is over nine years old, M.S. filed a report with the Hopkins Police Department within a week of the occurrence. And the police conducted interviews with both M.S. and Respondent. The report and interviews, which were tape-recorded and transcribed, were available to Respondent to assist in his defense.

Respondent received a fair hearing with sufficient procedural due process safeguards. The remoteness of the incidents alleged by M.S. and A.D. and Respondent's and his patients' somewhat limited recollections with respect to specific details, is not enough to establish unfair prejudice or a due process violation on the part of the Respondent.

### **G.A.B.**

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<sup>[1]</sup> "T." refers to the transcript of the hearing in this case, which began November 13, 2000, and concluded November 30, 2000. T. 348

<sup>[2]</sup> T. 343-344.

<sup>[3]</sup> T. 1568.

<sup>[4]</sup> T. 1568-1575.

<sup>[5]</sup> T. 1576-1577, 1972.

<sup>[6]</sup> T. 1591.

<sup>[7]</sup> T. 1618.

<sup>[8]</sup> T. 1619-1620, 2013.

<sup>[9]</sup> T. 155.

<sup>[10]</sup> T. 1732.

<sup>[11]</sup> T. 1067-1068, 1296-1297.

<sup>[12]</sup> T. 1607.

<sup>[13]</sup> T. 1265, 1608, 1610.

<sup>[14]</sup> T. 1612.

<sup>[15]</sup> T. 1612-1613.

<sup>[16]</sup> T. 1611, 1613, 1615.

<sup>[17]</sup> T. 1168-1170, 1611, 1616.

<sup>[18]</sup> T. 1417.

<sup>[19]</sup> T. 1399-1400.

<sup>[20]</sup> T. 1400.

<sup>[21]</sup> T. 1402-1403.

<sup>[22]</sup> T. 1408.

<sup>[23]</sup> T. 1588.

<sup>[24]</sup> T. 1406-1407, 1409-1410.

<sup>[25]</sup> T. 1411.

<sup>[26]</sup> T. 1589.

<sup>[27]</sup> T. 1412-1425.

<sup>[28]</sup> T. 1199, 1233, 1589, 2020.

<sup>[29]</sup> T. 137-138, 178, 243-244, 1042, 1062, 1198, 1200, 1234, 1262, 1292, 1558-1559, 1585-1586, 2012-2013.

<sup>[30]</sup> T. 1589.

- [31] T. 393.
- [32] T. 1581-1584.
- [33] T. 1800-1801.
- [34] T. 1800-1801.
- [35] T. 1977-1979.
- [36] Ex. 51.
- [37] T. 1900, 1980.
- [38] Ex. 51, p. 39; T. 1978.
- [39] Ex. 51, p. 32-38.
- [40] T. 75-77, 169.
- [41] T. 77, 81-82.
- [42] T. 80-83, 1353-1354.
- [43] T. 82-83, 1785-1786.
- [44] T. 82-83.
- [45] T. 2066-2067.
- [46] T. 2062.
- [47] T. 2063, 2066.
- [48] T. 2064.
- [49] T. 2073-2076.
- [50] T. 2073-2074.
- [51] T. 2074-2075.
- [52] T. 2073.
- [53] T. 2087-2090.
- [54] T. 2122-2125, 2145-2146.
- [55] T. 2128-2130.
- [56] T. 2129-2130.
- [57] T. 2131-2135.
- [58] T. 581-584.
- [59] T. 588.
- [60] Id.
- [61] T. 585, 732-733.
- [62] T. 588-590.
- [63] T. 643 and 650.
- [64] T. 650-651.
- [65] T. 644 and 651. See also, T. 900-901.
- [66] T. 651.
- [67] T. 642-643.
- [68] T. 77-78, 170, 280, 392, 1110, 1195, 1229-1232, 1287.
- [69] T. 280-281, 1110, 2087.
- [70] T. 170, 393, 1585, 1974.
- [71] T. 1194, 1229-1232.
- [72] T. 1197, 1230, 1288.
- [73] T. 1584-1586, 2067-2068.
- [74] T. 1579-1580, 1973-1974, 2085-2086.
- [75] T. 2137.
- [76] Id., 1580.
- [77] T. 2137-2138.
- [78] Id.
- [79] Id.
- [80] T. 2138-2139.
- [81] T. 2139, 2141.
- [82] T. 2145-2146.
- [83] T. 648.
- [84] T. 649-650.
- [85] T. 650.
- [86] T. 2070.

[87] T. 2070-2072.  
[88] T. 2069.  
[89] T. 2071.  
[90] T. 78, 393, 1048, 1974.  
[91] T. 1229.  
[92] T. 645-646.  
[93] T. 646-647.  
[94] T. 2146.  
[95] T. 1643.  
[96] T. 1107-1109.  
[97] T. 830.  
[98] T. 691.  
[99] T. 691 and 696.  
[100] T. 696.  
[101] T. 692.  
[102] T. 87.  
[103] T. 1103-1107; Ex. 6.  
[104] T. 1107; Ex. 6 and 72.  
[105] T. 1106, 1135.  
[106] T. 1110.  
[107] T. 1113-1115, 1125, 1502; Ex. 5, 6 and 73.  
[108] T. 1116, 1135, 1160.  
[109] T. 1166, 1627.  
[110] T. 1117, 1995; Ex. 83, p. 2-3.  
[111] T. 1117.  
[112] T. 1118.  
[113] T. 1118-1119, 1994-1995.  
[114] T. 1119-1120, 1146-1147, 1150.  
[115] T. 1119.  
[116] T. 1120-1121.  
[117] T. 1117.  
[118] T. 1122; Ex. 5.  
[119] Ex. 6.  
[120] T. 356-359, 633-634; Exs. 6 and 9.  
[121] T. 1781.  
[122] T. 1315, 1946, 1948-1949, 2077-2078; Exs. 58, 81.  
[123] T. 356.  
[124] T. 595-596.  
[125] T. 626-627.  
[126] T. 632-633. See also, T. 889-890.  
[127] T. 631.  
[128] T. 599-600.  
[129] T. 600-601, 736-743.  
[130] T. 1918-1922.  
[131] T. 741, 749.  
[132] T. 597.  
[133] T. 603, 1283, 1498.  
[134] T. 598.  
[135] T. 271-274; Ex. 9.  
[136] T. 267.  
[137] T. 269.  
[138] T. 277-279; Ex. 9.  
[139] T. 660, 1048.  
[140] T. 357, Ex. 9.  
[141] T. 283; Ex. 9.  
[142] T. 285.

[143] Ex. 9.  
[144] T. 284-285, T. 1048, 1061.  
[145] T. 1050.  
[146] T. 287, 1638.  
[147] T. 289.  
[148] T. 316-317, 1637, 2019.  
[149] T. 293-294; Ex. 9.  
[150] *Id.*  
[151] T. 377-378, 1987.  
[152] T. 378.  
[153] T. 292-293.  
[154] T. 345, 1592.  
[155] T. 346, 1592-1593.  
[156] T. 346.  
[157] T. 347, 762-763.  
[158] T. 347, 764-765.  
[159] T. 346, 1595, 1995.  
[160] T. 346.  
[161] T. 347, 766-767, 1996.  
[162] T. 348, 768-770, 1996; Ex. 16.  
[163] T. 347-348, 762, 1995-1996.  
[164] T. 786, 1708.  
[165] T. 775, 2002-2003.  
[166] T. 2003-2004.  
[167] T. 821-822, 827, 836.  
[168] T. 350-351, 353-355, 781-786, 819-821; Exs. 14-16.  
[169] T. 350-351; Ex. 14-15.  
[170] Ex. 16; T. 351-353, 783-786.  
[171] Exs. 14-15.  
[172] Ex. 16.  
[173] T. 1996-1997.  
[174] T. 355.  
[175] T. 1047, 1502-1504.  
[176] Exs. 14-15.  
[177] Ex. 17.  
[178] T. 658. See also, T. 890.  
[179] T. 657-658.  
[180] T. 661-663.  
[181] T. 778, 779-781, 831-833.  
[182] T. 832.  
[183] T. 366-367, 833-835.  
[184] T. 366, 834.  
[185] T. 835-837.  
[186] T. 837.  
[187] T. 837-839.  
[188] T. 838-839.  
[189] T. 841-842.  
[190] T. 65-67, 69.  
[191] T. 66-67.  
[192] T. 68-70.  
[193] T. 67, 70.  
[194] T. 876-877.  
[195] T. 68, 877.  
[196] T. 162-163, 1045-1046.  
[197] *Id.*  
[198] T. 1046.

[199] T. 1928.  
[200] T. 1928-1930, Ex. 76.  
[201] T. 1929.  
[202] T. 1672.  
[203] T. 1707-1708.  
[204] T. 1672, 1931-1932.  
[205] T. 1708.  
[206] T. 773-774.  
[207] T. 773-774, 1708.  
[208] T. 789-790.  
[209] T. 1532, 1539-1540.  
[210] T. 794, 1537.  
[211] T. 1648-1660.  
[212] T. 1653-1654.  
[213] T. 1650, 1652, 1654-1655, 1659.  
[214] T. 1657.  
[215] T. 61, 926.  
[216] Ex. 30.  
[217] T. 383-385, 994, 1999  
[218] T. 1749.  
[219] T. 1749.  
[220] T. 996-1002.  
[221] T. 1004.  
[222] T. 842-843.  
[223] T. 844.  
[224] T. 844, 1003, 1013.  
[225] T. 846-847.  
[226] T. 72-73.  
[227] T. 846, 848.  
[228] T. 1002-1003.  
[229] T. 389, 1969.  
[230] T. 388, 392, 1752.  
[231] T. 1752.  
[232] T. 2033.  
[233] T. 634-637.  
[234] T. 639-641.  
[235] T. 641.  
[236] T. 642.  
[237] T. 214-217, 222-231, 375.  
[238] T. 212; Ex. 7.  
[239] T. 214-215.  
[240] T. 216-217.  
[241] T. 218, 246.  
[242] T. 222-223.  
[243] T. 222.  
[244] T. 245-246.  
[245] T. 219, 224.  
[246] T. 225-226.  
[247] T. 226-227.  
[248] T. 228, 1987.  
[249] T. 229.  
[250] T. 249, 1678.  
[251] T. 250, 1679.  
[252] T. 1679.  
[253] T. 232-233, 826-827.  
[254] T. 252, 829.

- [255] T. 232, 827.  
[256] T. 234, 828-829.  
[257] T. 234.  
[258] T. 376, 1964-1965.  
[259] T. 376-377.  
[260] T. 656.  
[261] T. 1603.  
[262] T. 125, 179, 1202, 1238, 1283.  
[263] T. 189-194, 384, 1004-1005; Ex. 4.  
[264] T. 191-192.  
[265] T. 200.  
[266] T. 194-195.  
[267] T. 195-196; Ex. 4.  
[268] T. 197.  
[269] T. 1599-1601.  
[270] T. 1600-1602, Ex. 53.  
[271] T. 1600, 1603-1604.  
[272] T. 1179-1180.  
[273] T. 1180, 1183.  
[274] T. 1471.  
[275] T. 1006-1007.  
[276] T. 386-387, 1007.  
[277] T. 385-387, 1005-1007; Ex. 62.  
[278] T. 387; Ex. 62.  
[279] T. 387-388, 1008; Ex. 62.  
[280] T. 786-787, 1708.  
[281] T. 1710-1711.  
[282] T. 970-971, 1711.  
[283] T. 940-942, 944, 1709.  
[284] T. 1446.  
[285] T. 788.  
[286] *Id.*  
[287] T. 788, 849, 1074-1075, 1078-1079.  
[288] T. 788-789, 850-852, 904-905.  
[289] T. 789, 851-852, 907-909.  
[290] T. 789, 852, 909.  
[291] T. 909.  
[292] T. 1085.  
[293] T. 787, 853.  
[294] T. 856, 2026.  
[295] T. 771, Ex. 16.  
[296] T. 771, 939-940.  
[297] T. 423, 1692; Exs. 11 and 12.  
[298] T. 424.  
[299] T. 424-427.  
[300] T. 448-460; Exs. 11 and 12.  
[301] T. 1693-1694.  
[302] T. 448, 569.  
[303] T. 432, 1693-1694.  
[304] T. 459-460; Ex. 12, p. 3.  
[305] T. 423, 433.  
[306] T. 465.  
[307] *Ibid.*  
[308] T. 466.  
[309] T. 561.  
[310] T. 504-516; Ex. 11.

[311] T. 507.  
[312] T. 510-511.  
[313] T. 512.  
[314] T. 522.  
[315] T. 516-517.  
[316] T. 517-518.  
[317] Ex. 11, p. 12; (emphasis in the original.)  
[318] T. 520.  
[319] Ex. 11, T. 766, 773.  
[320] T. 1803-1805.  
[321] T. 1807-1809.  
[322] T. 1808, 1810.  
[323] T. 1810.  
[324] T. 1811.  
[325] T. 1822.  
[326] T. 1817.  
[327] T. 1818-1821.  
[328] T. 1818.  
[329] T. 1818-1819.  
[330] T. 1819.  
[331] T. 1823.  
[332] T. 1823.  
[333] T. 1823-1824.  
[334] T. 1821.  
[335] T. 1825-1826.  
[336] T. 1826-1827.  
[337] T. 1826.  
[338] Ex. 34; T. 1834-1835, 1838-1839, 1840-1841.  
[339] T. 1816.  
[340] T. 1817.  
[341] T. 1839-1840.  
[342] T. 1832, 1839.  
[343] T. 1838-1842.  
[344] T. 1849.  
[345] *ibid.*  
[346] T. 1851.  
[347] T. 1855.  
[348] *ibid.*  
[349] T. 1856.  
[350] *ibid.*  
[351] T. 1856-1857.  
[352] *ibid.*  
[353] T. 1857-1858.  
[354] T. 1858.  
[355] T. 1859, Ex. 74.  
[356] T. 1860, 1863.  
[357] T. 1861, 1863-1864, 1866.  
[358] T. 1866-1867.  
[359] T. 1863.  
[360] T. 1890.  
[361] T. 1891-1892.  
[362] T. 1892.  
[363] T. 1893.  
[364] T. 1893, 1895.  
[365] T. 1895-1896.  
[366] T. 1896.

[367] T. 1898.  
[368] *Ibid.*  
[369] T. 1898-1899.  
[370] T. 1901.  
[371] T. 45, 133, 181, 937, 1246, 1336, 1408, 1482, 1555.  
[372] T. 344-345.  
[373] "Ex." refers to the exhibits received into evidence at the hearing in this case. Ex. 2.  
[374] T. 1782, Ex. 2.  
[375] Minn. R. 1400.7300, subp. 5. *See also, In Re Wang*, 441 N.W.2d 488, 492 (Minn. 1989).  
[376] T. 363-364, 389-390, 469, 471, 481, 491.  
[377] T. 379-380, 391.  
[378] T. 1987.  
[379] T. 1785.  
[380] T. 1964.  
[381] T. 1751.  
[382] T. 1292, 1509.  
[383] *Padilla vs. Minnesota State Board of Medical Examiners*, 282 N.W.2d 876, 886 (Minn. App. 1986) *rev. denied*, (Minn. April 24, 1986).  
[384] T. 138, 178, 509.  
[385] T. 141-142.  
[386] 441 N.W.2d 488 (Minn. 1989).  
[387] 441 N.W.2d at 491.  
[388] 441 N.W.2d at 492.  
[389] T. 1918.  
[390] T. 289.  
[391] T. 287.  
[392] T. 316 and 337.  
[393] T. 284.  
[394] T. 1061.  
[395] Ex. 70.  
[396] T. 1938-1942.  
[397] T. 2018.  
[398] 441 N.W.2d at 493.  
[399] Ex. 11 p. 11.  
[400] Ex. 11 p. 9.  
[401] T. 1767-1773.  
[402] T. 1767-1773.  
[403] 375 N.W.2d 509, 517 (Minn. App. 1985).  
[404] *Id.*; *See also, Reyburn v. Minnesota State Bd. of Optometry*, 78 N.W.2d 351, 355-356 (Minn. 1956).  
[405] *See, Neeland v. Clearwater Memorial Hospital*, 257 N.W.2d 366, 369 (Minn. 1977); *In re Rochester Ambulance Service*, a Div. of Hiawatha Aviation of Rochester, 500 N.W.2d 495, 499-500 (Minn. App. 1993); *Holt v. State Bd. of Medical Examiners*, 431 N.W.2d 905, 906 (Minn. App. 1988), *rev. denied* (Minn. Jan. 13, 1989).  
[406] *State v. Crims*, 540 N.W.2d 860, 867 (Minn. App. 1995), *rev. denied* (Minn. January 23, 1996).  
[407] *See, State v. Normandale Properties, Inc.*, 420 N.W.2d 259, 261 (Minn. App. 1988), *rev. denied* (Minn. May 4, 1988).  
[408] *Minnesota League of Credit Unions v. Minnesota Dept. of Commerce*, 486 N.W.2d 399, 404 (Minn. 1992), *citing State v. Century Camera, Inc.*, 309 N.W.2d 735, 744 (Minn. 1981) (*quoting Grayned v. City of Rockford*, 408 U.S. 104, 92 S.Ct. 2294, 33 L.Ed.2d 222 (1972)).  
[409] *Humenansky v. Minnesota Bd. of Medical Examiners*, 525 N.W.2d 559, 564 (Minn. App. 1994), *rev. denied* (Minn. Feb. 14, 1995); *citing Kolender v. Lawson*, 461 U.S. 352, 357, 103 S.Ct. 1855, 1858, 75 L.Ed.2d 903 (1983); *Baggett v. Bullitt*, 377 U.S. 360, 367, 84 S.Ct. 1316, 1320, 12 L.Ed.2d 377 (1964); *State v. Newstrom*, 371 N.W.2d 525, 528 (Minn. 1985).  
[410] *Proetz v. Minnesota Bd. of Chiropractic Examiners*, 382 N.W.2d 527, 534 (Minn. App. 1986), *rev. denied* (Minn. May 16, 1986), *citing Matter of Welfare of A.K.K.*, 356 N.W.2d 337, 343 (Minn. App. 1984).  
[411] *Reyburn, v. Minnesota Bd. of Optometry*, 247 Minn. 520, 78 N.W.2d 351 (Minn. 1956).

[\[412\]](#) *Id.* at 355.

[\[413\]](#) *Id.* at 356.

[\[414\]](#) Minn. R. 1400.7300, subp. 5 (1999); *In re Friedenson*, 574 N.W.2d 463, 466 (Minn. App. 1998), *rev. denied*, (Minn. April 30, 1998).

[\[415\]](#) Minn. R. 1400.7300, subp. 5 (1999); *In re Wang*, 441 N.W.2d 488, 492 (Minn. 1989).

[\[416\]](#) *Painter v. Abels*, 998 P.2d 931 (Wyo. 2000); *Johnson v. Bd. of Gov. of Registered Dentists*, 913 P.2d 1339 (Okla. 1996); *Davis v. Wright*, 503 N.W.2d 814 (Neb. 1993); *Ettinger v. Bd. of Medical Quality Assurance*, 135 Cal. App.3d 853, 185 Cal. Rptr. 601 (1982).

[\[417\]](#) 441 N.W.2d 488, 492 (Minn. 1989).

[\[418\]](#) *Id.* at 492 and n. 5. (The court declined to consider the dentist's equal protection argument because it had been raised for the first time on appeal).

[\[419\]](#) *Id.* at 492.

[\[420\]](#) 473 N.W.2d 869 (Minn. App. 1991), *rev. denied* (Minn. Sept. 25, 1991).

[\[421\]](#) *Id.* at 874.

[\[422\]](#) *Id.* See also, *In Re Polk*, 90 N.J.550, 449A.2d 7, 17-19 (1982).

[\[423\]](#) 574 N.W.2d 463 (Minn. App. 1998), *rev. denied* (Minn. April 30, 1998).

[\[424\]](#) *Id.* at 466.

[\[425\]](#) *Wang* at 492.

[\[426\]](#) *Leisure Hills v. Minnesota Dep't. of Human Services*, 480 N.W.2d 149, 151 (Minn. App. 1992).

[\[427\]](#) *Fetsch v. Holm*, 236 Minn. 158, 163, 52 N.W.2d 113, 115 (1952).

[\[428\]](#) See e.g., *In re N.P.*, 361 N.W.2d 386, 392 (Minn. 1985), *appeal dismissed* 106 S.Ct. 375 (1985); *Fischer v. Independent School Dist. No. 622*, 357 N.W.2d 152 (Minn. App. 1984) (upholding elementary school principal's discharge for sexual misconduct based on events that did not come to light until 12 years later).

[\[429\]](#) 357 N.W.2d 152, 155-56 (Minn. App. 1984).

[\[430\]](#) *Id.*

[\[431\]](#) *Id.*

[\[432\]](#) *In re N.P.*, 361 N.W.2d 386, 392 (Minn. 1985).

[\[433\]](#) *Id.*

[\[434\]](#) *Id.*; See also, *Matter of Schroeder*, 415 N.W.2d 436, 441 (Minn. App. 1987), *rev. denied* (Minn. Jan. 28, 1988) (Board of Psychology's two year delay in bringing disciplinary proceeding against psychologist did not violate due process in absence of evidence as to when Board first received complaints).